

F.O.R. STATE
HEALTH DEPT.

TO DEPUTY JUDICIAL EXAMINER: This certificate should be executed within 24 hours after death unless necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PRM-2. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												14528			
1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b. HOUR						
Thomas			Hobart	AINSWORTH		DEATH ESTIMATED	<input type="checkbox"/>	10 23 1968	M						
3. SEX		4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF OVER 24 HRS HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month Oct. Day 23 Year 1968			2d. HOUR 725P			
Male		Cauc	Nov. 17, 1896	71 YRS											
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		9. COUNTY OF DEATH	Montgomery			Md.			
New York		USA						Montgomery							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Bethesda			Naval Hospital			Psychiatrist			Public Health						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER								
Maryland			Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5312 Hampden Lane						
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last				
George R.					AINSWORTH	GRACE					ABBOTT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Bethesda, Md. ADDRESS						
Yes			1939-48			Mrs. Mary H. Ainsworth,			5312 Hampden Lane						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4109 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>John G. Ball.</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) John G. Ball, M. D.						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10-28-68			23c. NAME OF CEMETERY OR CREMATORIAL Forest Hill Cemetery			23d. LOCATION (City or Town) Utica, New York			(County) (State)			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Maryland			ADDRESS			25a. REC'D BY REGISTRAR NOV 4 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

卷之三

51004

-6-

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14521

14529

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Timothy			First Dixon	Middle Aldredge	Last	2a. DATE OF DEATH Month October	Day 16	Year 1968	2b. HOUR A 6:30 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 17 September 1959		6. AGE (In years lost birthday) 9		IF UNDER 1 YEAR MONTHS 9		IF UNDER 24 HRS. MONTHS 0	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY --					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE West Virginia		13b. COUNTY Logan		13c. CITY OR TOWN Logan		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 120 Terrace Drive			
14. FATHER'S NAME First James		Middle C.	Last Aldredge	15. MOTHER'S MAIDEN NAME First LaJeana		Middle 	Last Williamson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Right Middle Lobe, Resolving								6 Weeks			
2040 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost.											
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Lymphocytic Leukemia								5 Years			
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (1) (this hospital) attended the deceased from 12 August, 1968 , to 16 Oct., 1968 , that (2) (we) last saw the deceased alive on 16 October 1968 , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above, (4) (we) (did) <input type="checkbox"/> view the body after death.											
22b. SIGNATURE <i>David H. Riddick, M.D.</i>		22c. DATE SIGNED 10/16/68									
22d. PHYSICIAN'S NAME (Type) David H. Riddick, M. D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/19/68		23c. NAME OF CEMETERY OR CREMATORIAL Forrest Lawn Cemetery		23d. LOCATION (City or Town) Pecks Mill, Logan Co. W. Va.		(County) 		(State) 	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS 7557 Wisconsin Ave., Bethesda, Maryland		25a. RECEIVED BY REGISTRAR OCT 21 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

23

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14522

14530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First BABY	Middle GIRL	Lost ALLEN	20. DATE OF DEATH Month October	Day 26	Year 1968	26. HOUR 10:04 P.M.	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH 25 October 1968			6. AGE (In years last birthday) YRS. 1		IF UNDER 1 YEAR MONTHS 1	IF UNDER 24 HRS. HOURS 10:04 P.M.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	9. COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL, NNMC	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N.A.			12b. KIND OF BUSINESS OR INDUSTRY N.A.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY 3	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER				
14. FATHER'S NAME JAMES	First OLE	Middle ALLEN	Lost	15. MOTHER'S MAIDEN NAME GAIL	First ANN	Middle MANTER	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. NONE	17. INFORMANT JAMES OLE ALLEN	361 JAMES STREET FALLS CHURCH, VA.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema associated with extensive subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF 1720 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 17600								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 10 Month Oct Day 25 Year 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No. 1		City or Town 2204	County 10/269	State 68	
22a. I certify that (I) (this hospital) attended the deceased from 0239 10/25 1968 , to 2204 10/269 68 , that (I) (we) last saw the deceased alive on 26 October 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did / did not view the body after death.								
22b. SIGNATURE G. H. Saffey		DEGREE V	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 26 October 1968		
22d. PHYSICIAN'S NAME (Type) G. H. Saffey M. D.		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10/28/68	23c. NAME OF CEMETERY OR CREMATORIAL MILLER CEMETERY		23d. LOCATION (City or Town) TEMPLE	(County) HILLSBORO	(State) N.H.	
24. FUNERAL DIRECTOR R.A. PUMPHREY 7557 WISCONSIN AVE, MARYLAND		ADDRESS BETHESDA	25a. REC'D BY REGISTRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

14291

RECORDED IN THE
REGISTRY OF TRADEMARKS.

Item23b FilmG406 11/8/68 kk MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH

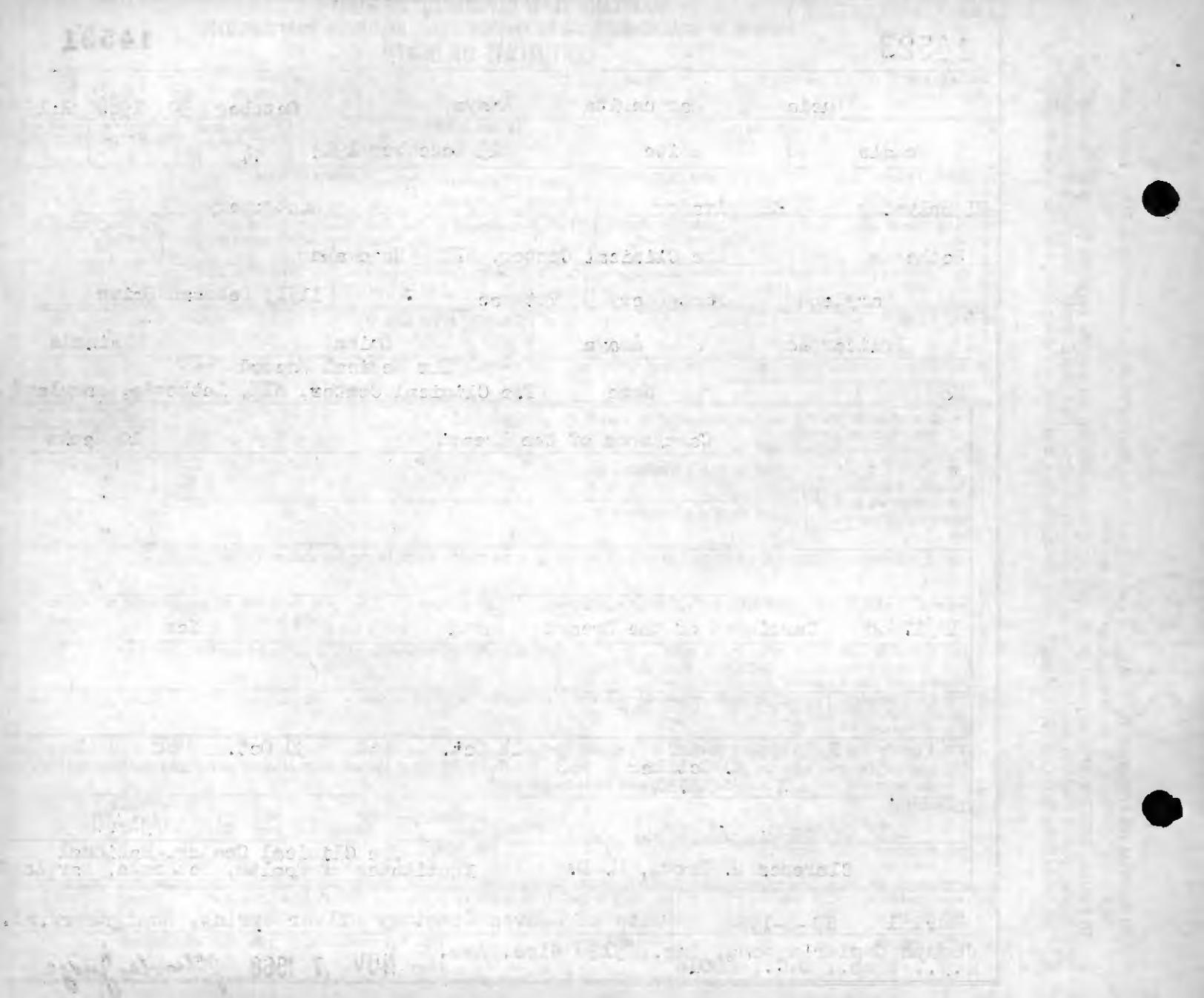
14531

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Lucia	Middle Marguerita	Lost Amaya	20. DATE OF DEATH Month October	Doy 30	Year 1968	2b. HOUR P 2:15 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH 13 December 1913		6. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) El Salvador	7b. CITIZEN OF WHAT COUNTRY? El Salvador	B. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 11513 Deborah Drive			
14. FATHER'S NAME Policarpio	First Middle Amaya	15. MOTHER'S MAIDEN NAME Luisa		Middle Pineda	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. None	17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Weeks			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Breast DUE TO, OR AS A CONSEQUENCE OF 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 170X							
19a. MEDICAL CERTIFICATION DATE OF OPERATION 10/17/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the Breast		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>14 Oct.</u> , 1968, to <u>30 Oct.</u> , 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>30 October</u> 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Clarence H. Brown, M.D.</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/31/68		
22d. PHYSICIAN'S NAME (Type) Clarence H. Brown, M. D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-2-1968	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery	23d. LOCATION (City or Town) Silver Spring, Montgomery, Md.	(County)	(State)	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS	25a. REC'D BY REGISTRAR DATE NOV 7 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14526

14532

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon borders. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First MARGARET	Middle M.	Last ANDERSON	2d. DATE OF DEATH Month OCTOBER	Day 3	Year 1968	2b. HOUR 8:508 M						
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 7/29/83			6. AGE (In years last birthday) 95	YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	MIN. 0		
7d. BIRTHPLACE (State or foreign country) D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY										
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) AT HOME			12b. KIND OF BUSINESS OR INDUSTRY SAME								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13c. CITY OR TOWN TAKOMA PARK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 7713 GREENWOOD AVE										
14. FATHER'S NAME First NOLAN	Middle L	Last NOLAN	15. MOTHER'S MAIDEN NAME First NOT AVAILABLE										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT ALFRED V. ANDERSON - 7713 GREENWOOD AVE			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding Peptic Ulcer of Duodenum APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days													
5320 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5410													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) Generalized Atherosclerosis													
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. 1 Month Aug Day 3 Year 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. 9205 New Haven Ave Silver Spring Md.	City or Town Silver Spring		County Montgomery		State MD.						
22a. I certify that (I) (this hospital) attended the deceased from Aug , 1968, to Oct 3 , 1968, that (I) (we) last saw the deceased alive on Oct 3 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Morton Altshuler MD													
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 9205 New Haven Ave Silver Spring Md.			22c. DATE SIGNED 10-3-68									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct 7, 1968	23c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery	23d. LOCATION (City or Town) Forest Glen Silver Spring			(County) MD.		(State) MD.					
24. FUNERAL DIRECTOR Arthur Walters, 254 Carroll St NW Wash DC	ADDRESS DA OCT 7 1968			25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge								

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14525

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14533

1. DECEASED NAME (Type or print)	First HARRY	Middle S.	Last Aubinoe	2a. DATE OF DEATH Month 10	Day 28	Year 1968	2b. HOUR 8:30 A.M.		
3. SEX Male	4 RACE White	5. DATE OF BIRTH 11-29-1882		6. AGE (in years last birthday) 86 yrs.		IF UNDER MONTHS 86	YEAR 0	IF UNDER 24 HRS HOURS 0	MIN. 0
7a. BIRTHPLACE (State or foreign country) So. Carolina USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery County, Md.					
10. CITY OR TOWN OF DEATH Silver Spring, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sheet Metal Worker		12b. KIND OF BUSINESS OR INDUSTRY Construction					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE md.	13c. CITY OR TOWN Montgomery, Wheaton	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 12150 Georgia Ave.						
14. FATHER'S NAME First Samuel	Middle R.	Last Aubinoe	15. MOTHER'S MAIDEN NAME First Annie	Middle S.	Last Spont.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. 579-03-1918	17. INFORMANT Randall S. Aubinoe	Address Rockville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs			
4369 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Cerebrovascular accident						2 weeks			
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Endovascular aneurysm									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 10/27/68 , 19 19 , to 10/28/68 , 19 19 , that (I) (we) last saw the deceased alive on 10/27/68 , 19 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE Patrick J. Jameson, M.D.		22c. DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 10/28/68			
22d. PHYSICIAN'S NAME (Type) Patrick C. Wilson, M.D.		22e. ADDRESS 11718 Georgia Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-31-1968	23c. NAME OF CEMETERY OR CREMATORIAL Parham Cemetery	23d. LOCATION (City or Town) Rockville, Montgomery, Md.		(County) Montgomery, Md.		(State)		
24. FUNERAL DIRECTOR Glen Carter	ADDRESS 1001 E. Burnside, R.R. 8431 Co. Ave. S.S. Md.	25a. REC'D BY REGISTRAR DATE OCT 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



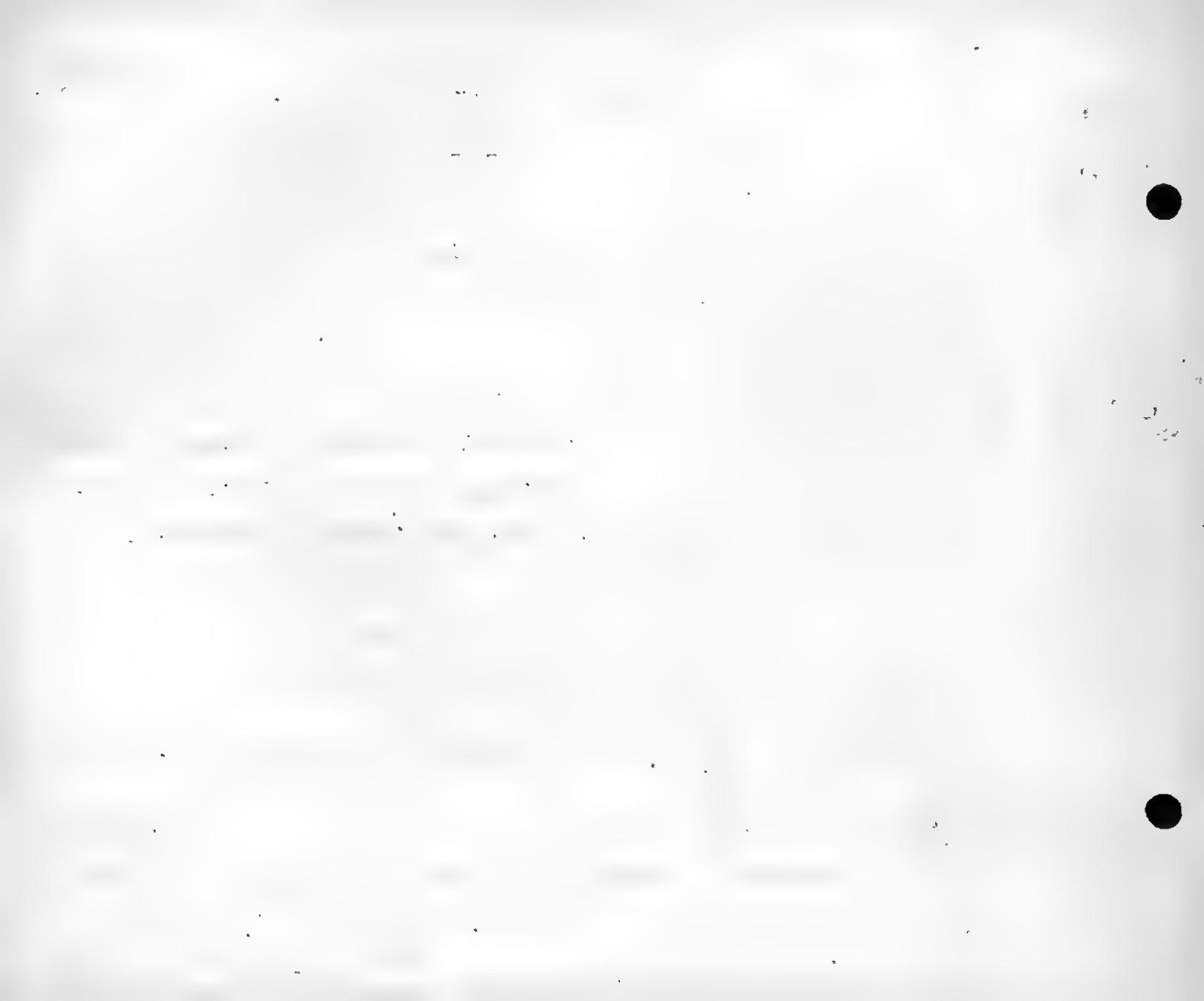
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper - page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

VR AI
20M 8EM

1. DECEASED-NAME (Type or print)		First Martha	Middle (NMN)	Lost Awkward	2a. DATE OF DEATH Oct. Month 26 Day 68 Year	2b. HOUR 12:40 M	
3. SEX Female	4 RACE Negro	5. DATE OF BIRTH 7-30-13		6. AGE (In years last birthday 35 yrs.)		If Under 1 Year Months Days Hours Min	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sandy Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First Wesley		Middle Marr	Lost	15. MOTHER'S MAIDEN NAME First Ruth		Middle	Lost Howard
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>1977</u> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMATOSIS, DIFFUSE</u> <u>ADENOCARCINOMA LIVER - METASTATIC</u> 6 mo. DUE TO, OR AS A CONSEQUENCE OF 3 DAYS.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1961							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (1) this hospital attended the deceased from <u>MAY 1964</u> , to <u>OCT 26, 1968</u> , that (2) (we) last saw the deceased alive on <u>OCT 26, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Donald R. Lewis MD</u>		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>OCT 27, 68</u>	
22d. PHYSICIAN'S NAME (Type) <u>DONALD R. LEWIS MD</u>		22e. ADDRESS <u>700 Coverly St. SILVER SPR. Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10-29-68</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Ash Memorial Cem.</u>		23d. LOCATION (City or Town) <u>Sandy Spring Party Rd.</u>		(County) (State)
24. FUNERAL DIRECTOR <u>Robert L. Lewis Rockville Md.</u>		ADDRESS	25a. REC'D. BY REGISTRAR <u>NOV 1 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



14527

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14535

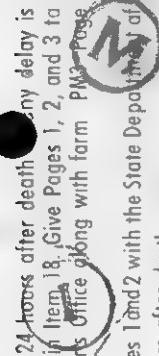
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First Hilda	Middle Augusta	Last Bailey	2a. DATE OF DEATH Month 10	Day 27	Year 1968	2b. HOUR 1:30 P.M.		
3. SEX female	4. RACE Caucasian	5. DATE OF BIRTH 1-17-1894		6. AGE (In years last birthday) 74	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS MIN. 0	
7a. B.RTHPLACE (State or foreign country) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens N.H.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D. C.	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5405 39th St. N.W.						
14. FATHER'S NAME First William	Middle Andrews	15. MOTHER'S MAIDEN NAME First Isabelle	Middle Wilson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 579-14-7890-B	17. INFORMANT Wilson W. Bailey, Husband, same as item #13	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-Sclerotic Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 35 yrs									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from 1960 , to 10/27 , 1968, that (II) (we) last saw the deceased alive on 10-27 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Marvin Fuchs M.D.		DEGREE M.D.	ATTENDING PHYS. ✓	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10-27-68			
22d. PHYSICIAN'S NAME (Type)		MARVIN FUHCS		22e. ADDRESS 5315 Connecticut Ave. D.C.					
23a. BURIAL, CREMATION, BURIAL (Specify)		23b. DATE 10-30-1968	23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery		23d. LOCATION (City or Town) Washington, D.C.		(County)	(State)	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge			
					DATE OCT 30 1968				

2) \int_{γ}

FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiners Office along with farm PIN 3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												14536		
1. DECEASED NAME (Type or Print)			First	Middle	Last	20. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			26 HOUR					
Catherine Margaret Baithis.						DEATH MATED <input type="checkbox"/>	Oct 15 1968	11:30 AM						
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday, months, days)	F UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS	21c. DATE PRONOUNCED DEAD Month Day Year			2d HOUR					
Fe-	W.	Jan. 18 1892	76 yrs			Oct. 15 1968	11:30 PM							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md					
Virginia		U.S.A.				Montgomery								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Gaithersburg			Asbury Methodist Home											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER						
Maryland						Strasburg								
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last					
Charles Atwell McCarty						Eugenie			Sommer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIA. SECURITY NO (If yes give war or dates of service)			17. INFORMANT	ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
						218-54-9113	Asbury Methodist Home Records			3 days				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Urinary tract Infection - Due to, or as a consequence of (c) Generalized Arterio Sclerosis - Due to, or as a consequence of												5 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture of Left Hip.												4 years.		
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?					
			18 Sept 1968			Repair of Hip Prosthesis.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) He fell in nursing home causing fracture								
			11:30 AM 9/14 1968											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town			County	State				
			Nursing Home.			Gaithersburg			Montgomery	Md.				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												22b. DATE SIGNED		
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			John G. Ball									Oct 16, 1968.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)			(County)	(State)	
Burial			10-18-68			Riverview			Strasburg			VA		
24. FUNERAL DIRECTOR			ADDRESS			Ernest C. Gartner			RECD BY REGISTRAR			REGISTRAR'S SIGNATURE		
			Gaithersburg, Md.						OCT 21 1968			Charles Judge		



14529

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14537

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with 24 hours after death.

1 DECEASED-NAME (Type or print)	First <i>ALFREDO</i>	Middle <i>BANOS</i>	Last	2a DATE OF DEATH Month 10	Day 20	Year 1968	2b HOUR 7 05 AM		
3. SEX <i>Male</i>	4. RACE <i>white</i>	5 DATE OF BIRTH <i>3-20-1881</i>	6 AGE (In years last birthday) 87 yrs.	7E UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF OVER 24 HRS HOURS 0	MIN 0		
7a. BIRTHPLACE (State or foreign country) <i>Mexico</i>	7b. CITIZEN OF WHAT COUNTRY? <i>MEXICO</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>MONTGOMERY</i>						
10 CITY OR TOWN OF DEATH <i>KENSINGTON</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>KENSINGTON Gardens Sanit</i>	12a USUAL OCCUPATION (kind of work done during most of working life, even if retired) <i>GOVERNMENT WORK</i>	12b KIND OF BUSINESS OR INDUSTRY <i>UNIVERSITY</i>						
13a USUAL RESIDENCE (Where deceased lived, if institut. on. Residence before admission) STATE <i>D.C.</i>	13b COUNTY	13c. CITY OR TOWN <i>Washington</i>	13d INSIDE CITY LIMT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>4701 Conn. Ave Apt 107</i>					
14. FATHER'S NAME First <i>Jose.</i>	Middle <i>P.</i>	Last <i>BANOS</i>	15. MOTHER'S MAIDEN NAME First <i>-</i>	Middle	Last <i>CONTREROS</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b SOCIAL SECURITY NO. <i>578-30 7454</i>	17 INFORM NT <i>DOLORES SCHNEIDER, DAUGHTER,</i>	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac decompensation</i> DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Postictal's disease</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Postictal's disease</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 19 1968</i> , to <i>Oct 20 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 19 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Andrew E. Rudnick</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS.	22c DATE SIGNED <i>10/20/68</i>				
22d PHYSICIAN'S NAME (Type) <i>ANDREW E RUDNICK</i>		22e ADDRESS <i>1720 Kildare Luther Blvd.</i>							
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>10-23-1968</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery</i>	23d LOCATION (City or Town) (County) (State)					
24 FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.,</i>		ADDRESS <i>5130 Wisc.Ave. N.W., Wash., D.C., 20016</i>	25a. RECEIVED BY REGISTRAR <i>OCT 23 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Andrew Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14530

14538

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)	First Theresa	Middle Barick	Last Barick	2a. DATE OF DEATH 10 Month 2 Day 68 Year	2b. HOUR 3:20 P.M.
3. SEX Female	4 RACE Cauc.	5. DATE OF BIRTH 1/1/1892		6. AGE (In years last birthday) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) N.Y., N.Y.	7b. CITIZEN OF WHAT COUNTRY? USA	B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		Md.
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INS. DE CITY J.M.P? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 10613 Cavalier Drive	
14. FATHER'S NAME Moscos	First Middle Monkes	Last Monkes	15. MOTHER'S MAIDEN NAME First Hannah	Middle (unknown)	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown [10]	16b. SOCIAL SECURITY NO. 220-54-1336	17. INFORMANT Rivolanne Sacks (same as 13 above)	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive arteriosclerotic vascular disease years DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)		
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCAT ON Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from June 1962 to Oct 2, 1968, that (I) (we) last saw the deceased alive on Oct 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <i>John Berger, M.D.</i>		ATTENDING PHYS MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED Oct 2-68		
22d. PHYSICIAN'S NAME (Type) JASON BERGER, M.D.		22e. ADDRESS 800 PERSHING DRIVE SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 4, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Washington Cem.	23d. LOCATION (City or Town) (County) (State) Beans, N.J.		
24. FUNERAL DIRECTOR Salisbury Fun. Home	ADDRESS 961 St. Louis	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE DATE OCT 4 1968 <i>Charles Judge</i>		



14531

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

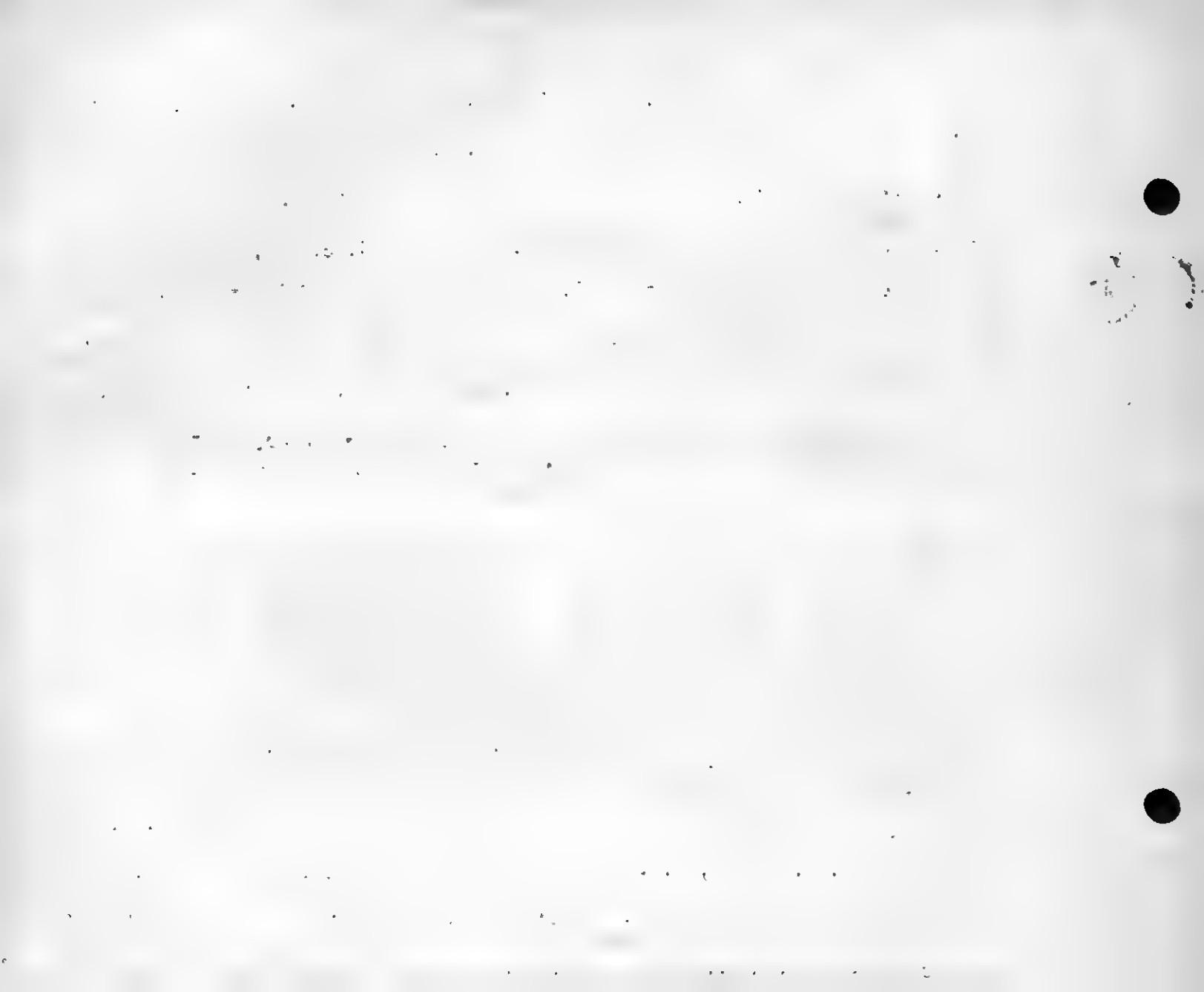
CERTIFICATE OF DEATH

14539

1. DECEASED NAME (Type or print) First Eugene			Middle P.	Lost BARRETT	20. DATE OF DEATH Oct. Month Oct. 31 Year 68	2b HOUR P 1253 M			
3. SEX Male		4. RACE Caucasian		S. DATE OF BIRTH Aug. 7, 1934	6. AGE (in years last birthday) 34.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 MIN. MIN. 0	
7a. BIRTHPLACE (State or foreign country) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Bethesda,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Illinois		13c. CITY OR TOWN S. Holland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 15500 State Street				
14. FATHER'S NAME First John Lawrence		Middle Barrett	Lost	15. MOTHER'S MAIDEN NAME First Grace	Middle Dugan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (Type or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT South Holland	Address Mrs. Rose Barrett, 15500 State Street,	Illinois			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT LYMPHOMA WITH MASSIVE INVOLVEMENT OF DUE TO, OR AS A CONSEQUENCE OF SMALL BOWEL AND SECONDARY SMALL BOWEL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from Oct. 17, 1968 , to Oct. 31, 1968 , that (I) (we) lost saw the deceased alive on Oct. 31, 1968 , and that in NO (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (NO) view the body after death.									
22b. SIGNATURE <i>M. D. Gorman</i>		DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Nov. 1, 1968			
22d. PHYSICIAN'S NAME (Type) M. D. GORMAN, M.D.		22e. ADDRESS Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 5, 1968	23c. NAME OF CEMETERY OR CREMATORIAL St. Patrick's Cemetery	23d. LOCATION (City or Town) Lowell	(County) Massachusetts	(State)			
24. FUNERAL DIRECTOR Francis Gasch's Sons ADDRESS 4739 Baltimore Ave., Hyattsville, Md.				25a. REC'D. BY REGISTRAR DATE NOV 6 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~exercised~~ within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~extra~~ than papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed ~~within~~ in 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

VR AT5 {4}
30M REV 1/68

14532

CERTIFICATE OF DEATH

14540

1. DECEASED-NAME (Type or print)			First Mabel S. Barton			Last			2a DATE OF DEATH		
									Month	Day	Year
3. SEX Female			4 RACE Cau			5. DATE OF BIRTH 5-9-88			6. AGE (in years lost birthday) 80		
									IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS	
7a BIRTHPLACE (State or Foreign country) N.Y.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife (Ret.)			12b. KIND OF BUSINESS OR INDUSTRY At Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.			13c CITY OR TOWN Wheaton			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 13002 Camellia DR.		
14. FATHER'S NAME First George			Middle Smedes			15 MOTHER'S MAIDEN NAME First Unknown			Middle Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b SOCIAL SECURITY NO. 143-07-5951			17 INFORMANT DeWitt A. Barton			Address 416 OLEANDER AVE Long Beach, Calif.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) HASCVD DUE TO, OR AS A CONSEQUENCE OF lost (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 mo.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 44											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC)			21f. LOCATION Street or RFD No			City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 1964 to 1968, that (I) (we) lost saw the deceased alive on 10/25/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Myron L. Lenkin M.D. DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. DATE SIGNED 10/25/68											
22d PHYSICIAN'S NAME (Type)		22e ADDRESS 2309 Sharsfield Road Wheaton, Md.									
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE 10/10/68		23c. NAME OF CEMETERY OR CREMATORIAL Facilities		23d. LOCATION (City or Town) Bladensburg Rd. P.C. Md.			(County)		(State)
24. FUNERAL DIRECTOR		ADDRESS West D.C.			25a. REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
W.W. Chambers Co. Inc.		1400 Clarendon St. NW			DATE NOV 4 1968			Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14533

CERTIFICATE OF DEATH

14541

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First HELEN	Middle CUFF	Last BEAN	2a. DATE OF DEATH Month Oct 22, 1968	Day 8	Year 1968	2b. HOUR 12:10			
3 SEX Female		4 RACE White		5 DATE OF BIRTH Aug. 5, 1888		6. AGE (In years last birthday) 80		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery					
10 CITY OR TOWN OF DEATH Burtonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 14824 Old Columbia Pike		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Burtonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 14824 Old Columbia Pike					
14. FATHER'S NAME First John Cuff		15. MOTHER'S MAIDEN NAME First Clara		Middle (Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No		16b. SOCIAL SECURITY NO 212-54-4625		17. INFORMANT Mrs Hilda A. Shank		Address 713 Hollywood Ave Silver Spring Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Edema								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-8 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Acute Bronchopneumonia		DUE TO, OR AS A CONSEQUENCE OF (b) Acute Bronchopneumonia						1 day			
DUE TO, OR AS A CONSEQUENCE OF (c) 491x											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Parkinsons Disease, Advanced Arthritis											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (the hospital) attended the deceased from 4-23 , 19 63 , to 10-22 , 19 68 , that (I) (we) last saw the deceased alive on 10-21 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John R. Spencer		22c. DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		DATE SIGNED 10-22-68	
22d. PHYSICIAN'S NAME (Type) John R. Spencer		22e. ADDRESS Burtonsville, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/24/68		23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		23d. LOCATION (City or Town) Burtonsville Montg.		(County) Montgomery		(State) Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1321 Rock. Pike Rockville, Maryland		25a. RECEIVED BY REGISTRAR DATE OCT 25 1968		25b. REGISTRAR'S SIGNATURE Charles Juge					
VR A15 14 30M REV 1/68											



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14534

14542

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have it give carbon papers. Please return to the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2d. DATE OF DEATH Month	Doy	Year	2b. HOUR P 7:45 M
GERTRUDE		M.		BEDELL	Oct.	17,	1968	
3. SEX Female		4 RACE Cauc.		5 DATE OF BIRTH Dec. 5, 1880	6 AGE (In years last birthday) 87	IF UNDER 1 YEAR MONTHS	IF JUNIOR 24 HRS DAYS	
7a BIRTHPLACE (State or foreign country) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U. S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery				
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grosvenor Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Waitress		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE District of Columbia		13b COUNTY	13c. CITY OR TOWN Washington	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6409 33rd St., N: W.			
14. FATHER'S NAME First Unknown		Middle	Last	15. MOTHER'S MAIDEN NAME First Gertrude M. Masterson		Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 405-30-3070A		17 INFORMANT Son	Address Daniel B. Bedell			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 41271		DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular Collapse					sec. hours	
Conditions, if any, which gave rise to named immediate cause (a), stating the underlying cause 41271		(b) DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Infarction					sec. hours	
(c) Generalized arteriosclerosis many years								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 41271 Stroke due to old age								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCAT.ON Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (the hospital) attended the deceased from 8/7 , 19 68 , to 10/12 , 19 68 , that (I) (we) last saw the deceased alive on 10/12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE George H. Mitchell		DEGREE MD	ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/18/68		
22d. PHYSICIAN'S NAME (Type) GEORGE H. MITCHELL		22e. ADDRESS 11125 Rockville Pike Rockville, Maryland						
23a. BURIAL CREMAT. ON, REMOVAL (Specify) Burial		23b. DATE 10-21-68	23c. NAME OF CEMETERY OR CREMATORIAL Calvary Cemetery		23d. LOCATION (City or Town) Louisville, Kentucky		(County)	(State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR OCT 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14543

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.



Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14535

1. DECEASED NAME (Type or print)	First John	Middle Gordon	Last BELL	2a. DATE OF DEATH Month OCT	Day 30	Year 68	2b. HOUR 0915 M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH 21 August 1946		6. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Tennessee	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital, Bethesda		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Fairfax	13c. CITY OR TOWN McLean	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6909 Lemon Road		
14. FATHER'S NAME First Gordon	Middle C.	Last BELL	15. MOTHER'S MAIDEN NAME First Elinor	Middle Powers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Capt. Gordon C. Bell, USN, Ret. McLean, Va.	Address 6909 Lemon Road				
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Hodgkins Disease with secondary gastric hemorrhage</u> 101X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 101X							
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (A) (this hospital) attended the deceased from 13 October 1968, to 30 October 1968, that (A) (we) last saw the deceased alive on 30 October 1968, and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>D. L. Horton</u>	DEGREE ATTENDING PHYS	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input checked="" type="checkbox"/>	22c. DATE SIGNED 31 OCT 1968
22d. PHYSICIAN'S NAME (Type) D. L. HORTON, M. D.	22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.						
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE 11-3-68	23c. NAME OF CEMETERY OR CREMATORIAL Highland Memorial			23d. LOCATION (City or Town) Knoxville (County) (State) Tenn.		
24. FUNERAL DIRECTOR Robert A. Pumphrey	ADDRESS 7557 Wisconsin Ave. Bethesda, Maryland		25a. REC'D BY REGISTRAR NOV 4 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14536

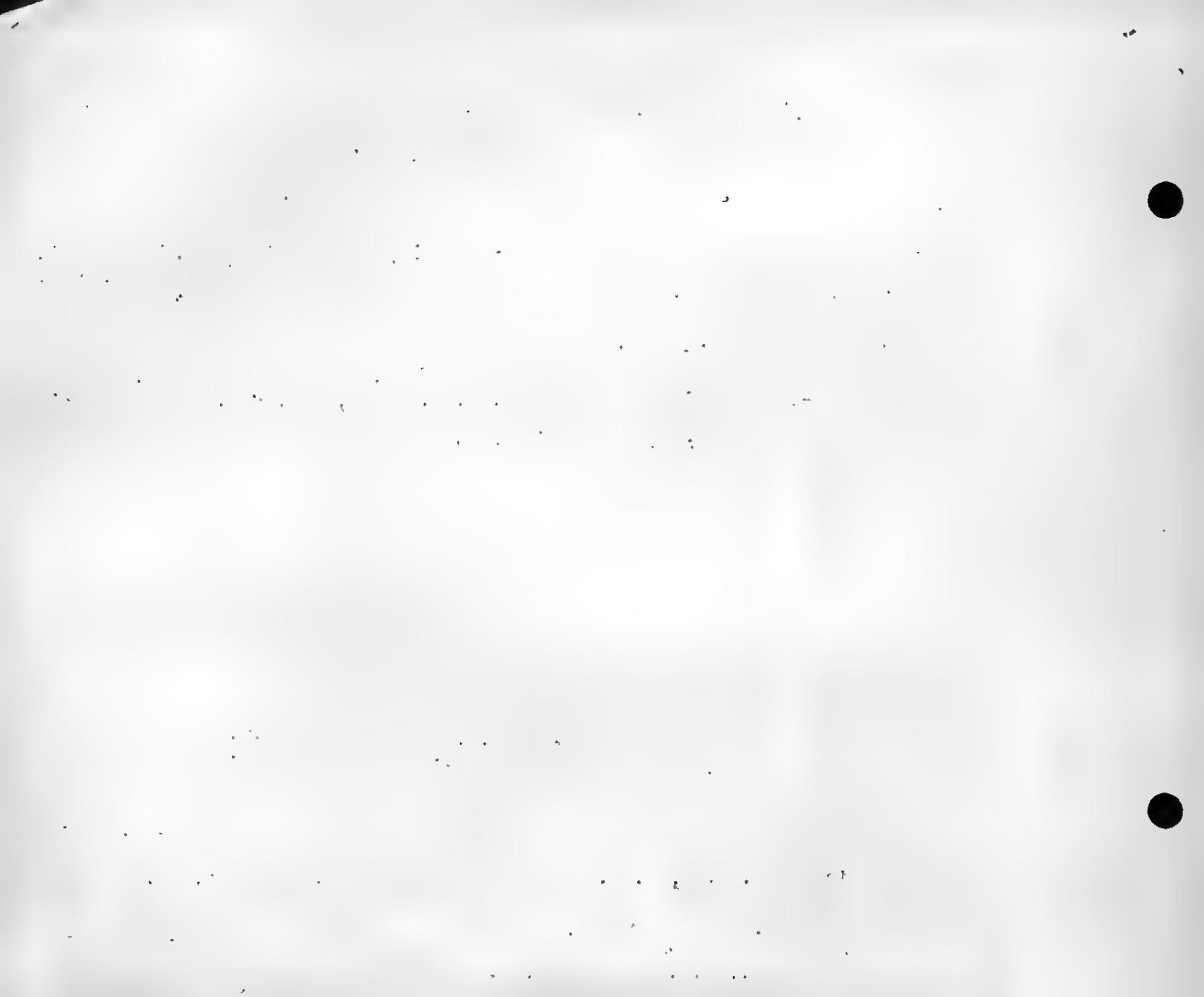
14544

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Joseph	Middle A.	Last BELL	2a. DATE OF DEATH Month October	Day 29	Year 68	2b. HOUR A 1055 M	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH March 27, 1904		6. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Colorado	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Physician/Epidemiologist		12b. KIND OF BUSINESS OR INDUSTRY Public Health		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9318 Elmhurst Drive				
14. FATHER'S NAME First Joseph	Middle Charles	Last Bell	15. MOTHER'S MAIDEN NAME First Bessie	Middle Sherman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 1942-46	17. INFORMANT Road, Rockville	Address Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction								
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b)								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
4201								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State		
1050 A.M. 1055 A.M.								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 29 Oct., 1968 to 29 Oct., 1968 , that (we) last saw the deceased alive on 7 August 1968 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.								
22b. SIGNATURE Richard N. Hood M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> DATE SIGNED 29 Oct. 1968								
22d. PHYSICIAN'S NAME (Type) Richard N. HOOD, M. D.	22e. ADDRESS Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-2-1968	23c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		23d. LOCATION (City or Town) Rockville, Montgomery Co., Md.		(County) (State)		
24. FUNERAL DIRECTOR Joseph Gawler Sons	ADDRESS 5130 Wisconsin Ave., N.W. Washington, D.C.	25a. REC'D BY REGISTRAR NOV 7 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 16a FilmG406 10-11-68

CERTIFICATE OF DEATH

14545

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it must be given to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First LOUIS	Middle JOHN	Last BENDER	2a DATE OF DEATH October Month 8 Day 68 Year	2b HOUR 146 M
3. SEX Male	4 RACE Caucasian	5. DATE OF BIRTH 7-23-1892		6 AGE (In years last birthday) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a USUAL OCCUPATION (Kind of work done most work in life, even if retired) Retired lab. Tech.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2804 Ivydale Street	
14. FATHER'S NAME First Rudolph	Middle Michael	Last Bender	15. MOTHER'S MAIDEN NAME First Louisa	Middle	Last -
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No <input type="checkbox"/> unknown 1909-1913	16b. SOCIAL SECURITY NO 218-05-6332-1	17. INFORMANT Mrs. Betty Clucas, Daughter,	Address		
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>Superior Vena Cava</u> (b) <u>Alveolar-Capillary block + blood obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchogenic carcinoma</u>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>9</u> , 19 <u>68</u> , to <u>10/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/7</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Rudolph</u>		17-11 DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>10/8/68</u>
22d. PHYSICIAN'S NAME (Type) Edward S. Mehlman		22e. ADDRESS 6480 New Hampshire Av Takoma Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-11-1968	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland, Prince Georges, Md. (County) (State)
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc.Ave. N.W., Wash., D.C., 20016		ADDRESS 5130 Wisc.Ave.	25a. REC'D. BY REGISTRAR DATE OCT 14 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



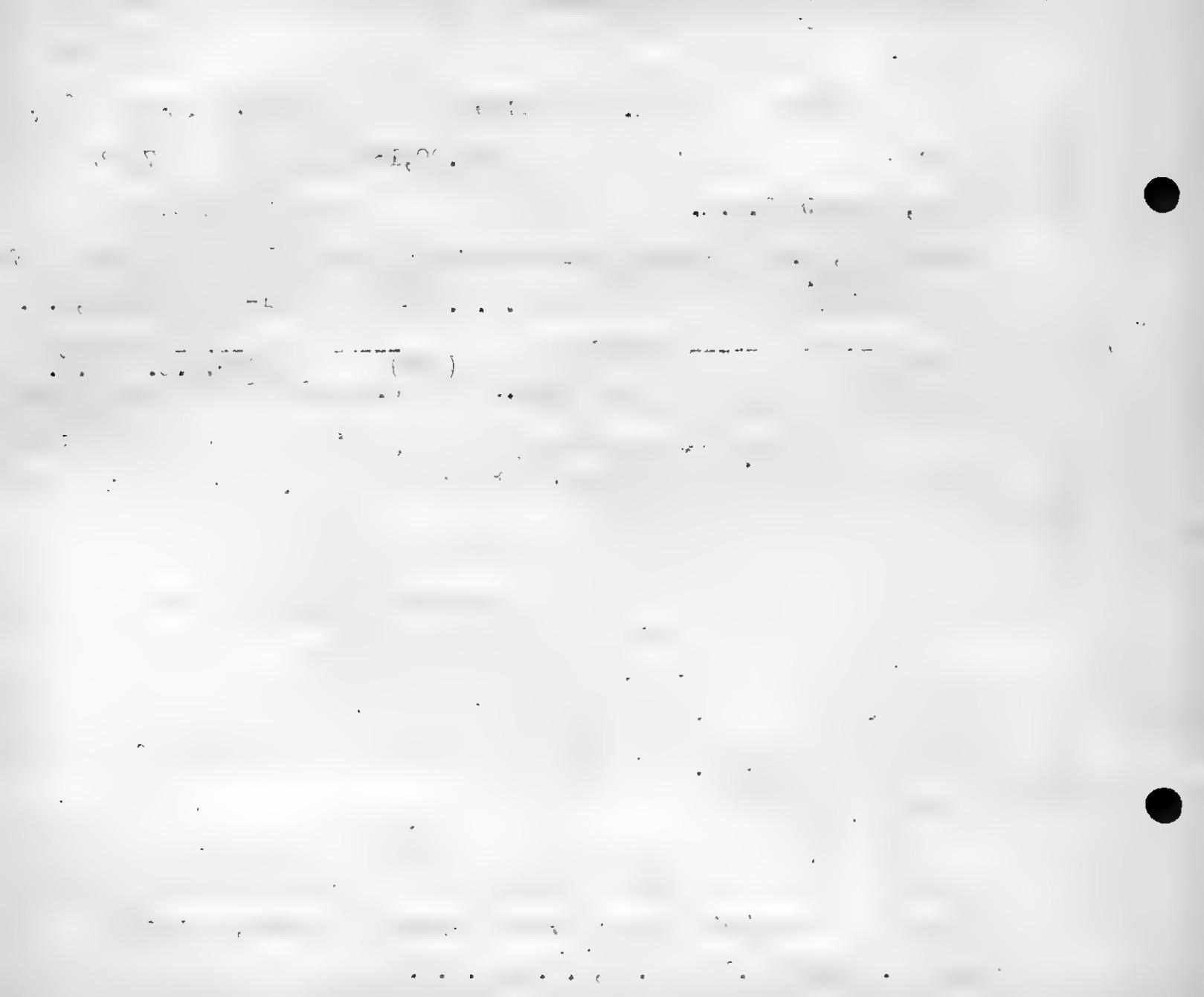
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14546

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in an event within 72 hours of its death.

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR 2:35 P.M.
EDITH BENNETT		H.	BENNETT		OCTOBER 21, 1968	
3. SEX FEMALE		4 RACE WHITE	5 DATE OF BIRTH FEB. 29, 1880		6 AGE (In years last birthday) 88 YRS	IF UNDER 1 YEAR MONTHS 7 DAYS 22 HOURS 2 MIN
7a BIRTHPLACE (State or foreign country) LONDON, ENGLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY COUNTY Md	
10. CITY OR TOWN OF DEATH KENSINGTON, MD.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL HALL SANITARIUM		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY HOME MAKER
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE OF COL. DISTRICT		13c CITY OR TOWN WASH. D.C.	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 5801 UTAH AVENUE, N.W.	
14 FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last				
HIBBARD		HIBBARD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT (SON) DR. SYDNEY J. BENNETT		WASH. D.C. N.W.
						5801 UTAH AVENUE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4229		DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 days.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral arteriosclerosis				27 days.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CRIME OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building Etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5 FEB. 1968 , to 21 OCT 1968 , that (I) (we) last saw the deceased alive on 21 Oct 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE John Richwine, M.D.		22c. DEGREE M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22d. DATE SIGNED 21 Oct 1968
22d. PHYSICIAN'S NAME (Type) John Richwine, M.D.		22e. ADDRESS 522 WESTERN AVE. WHEATON, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/24/1968	23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN CEMETERY		23d. LOCATION (City or Town) (County) (State) WHEATON, MARYLAND	
24. FUNERAL DIRECTOR MARTIN W. HYSON		ADDRESS OO! 1500 N. SP. N.W. WASH. D.C.		25a. REC'D BY REGISTRAR OCT 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



CERTIFICATE OF DEATH

14547

1. DECEASED-NAME (Type or print)		First David	Middle	Lost Bergart	20. DATE OF DEATH 10 Month 30 Day 68 Year	2b HOUR 5:30 P.M.
3 SEX <input checked="" type="checkbox"/> Male	4 RACE <input checked="" type="checkbox"/> Caucasian			S. DATE OF BIRTH MARCH 4, 1880 XXXXXX	6 AGE (In years last birthday) 88	IF UNDER 1 YEAR MONTHS DAYS XXXXXX
7a BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Montgomery	IF UNDER 24 HRS. HOURS MIN.
10 CITY OR TOWN OF DEATH Wheaton		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Bookbinder		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE D. C.		13c. CITY OR TOWN Washington		13d. INSIDE CITY LHM TS2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2101 16th St.	
14. FATHER'S NAME First Henry		Middle	Lost	15. MOTHER'S MAIDEN NAME First Sarah		Middle Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 106-7 INFORMANT 513-40-1067-XX		Address Don Bergart 3636 16th St. NW		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409		DUE TO, OR AS A CONSEQUENCE OF Conditions, injury which gave rise to immediate cause (a), stating the underlying cause lost. (b)		CVA vs Myocardial infarction Arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
DUE TO, OR AS A CONSEQUENCE OF (c)						chronic
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7500 none						
19a. DATE OF OPERATION 7500		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Injury to forehead from fall after		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1967, to Oct. 1968, that (I) (we) last saw the deceased alive on Oct. 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE R.C. Bufalino MD		DEGREE	ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED Oct 30, 1968.
22d. PHYSICIAN'S NAME (Type) R.C. Bufalino, M.D.		22e. ADDRESS 1429 University Blvd. N.W.				
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE NOV. 1, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Mount Lebanon Cemetery	23d. LOCATION (City or Town) Hyattsville, Maryland	(County)	(State)
24. FUNERAL DIRECTOR Donald M. Stein		ADDRESS Hebrew Memorial Funeral Home	250 REC'D BY REGISTRAR St., N.W. Wash., D.C.	25b. REGISTRAR'S SIGNATURE NOV 4 1968 Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Please sign and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

HOSPITAL OR ATTENDING PHYSICIAN: The hospital or attending physician may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14548

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. DECEASED NAME (Type or print)	First	Middle	Last	20. DATE OF DEATH Month	9 Day	Year	2b. HOUR
Stacy	LYNN	BERRY	Oct	1968	5A M		
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years lost birthday)				IF UNDER 1 YEAR
F	W	JAN. 19, 1961	77 YRS.	MONTHS	DAYS	HOURS	IF UNDER 24 HRS.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH				
tx	USA	Montgomery Co. Md.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring, Md.	Holy Cross Hosp.	CHILD	CHILD				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS	13e. STREET AND NUMBER				
ma.	monte	YES <input type="checkbox"/> NO <input type="checkbox"/>	2417 East Gate Dr.				
14. FATHER'S NAME	First	Middle	Last	IS MOTHER'S MAIDEN NAME	First	Middle	Last
William	L.	Berry	Carole	ANN	MARX		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address				
		William L. Berry	2417 East Gate Dr. - Father.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MALIGNANT MESODERMAL TUMOR</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)							22 mos.
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1992							
19c. MEDICAL CERTIFICATION		19d. DATE OF OPERATION	19e. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from Jan., 1967, to Oct., 1968, that (I) (we) last saw the deceased alive on 10/18/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>G. Leonard Gold</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED 10/19/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE OCT. 11, 1968	23c. NAME OF CEMETERY OR CREMATORIAL King David Memorial Garden	23d. LOCATION (City or Town) Falls Church, Virginia	(County)	(State)		
24. FUNERAL DIRECTOR Hebrew Memorial Funeral Home	ADDRESS 232 Carroll St., N.W. Wash., D.C.	25a. RECD. BY REGISTRAR OCT 14 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14549

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.



1. DECEASED NAME (Type or print)	First Baby Girl	Middle Bliss	Last	2a. DATE OF DEATH Month October Day 30, 1968	2b. HOUR P.M. 12:10 M
3. SEX Female	4. RACE White	S. DATE OF BIRTH October 30, 1968	6. AGE (in years last birthday) YRS 42	F. UNDER 1 YEAR MONTHS 0	F. UNDER 24 HRS. HOURS 0
7a. B.RTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Mont.	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 12020 Valleywood Drive	
14. FATHER'S NAME First James	Middle O'Donovan	Last Bliss	15. MOTHER'S MAIDEN NAME First Linda	Middle Ann	Last Dixon
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17. INFORMANT Father	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anencephaly Congenital (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____ _____					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Meningo-Encephalitis					
19a. DATE OF OPERATION 10/10/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ronald Chinn, M.D.		22c. DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10/30/68	
22d. PHYSICIAN'S NAME (Type) R. Chinn, M.D.,		22e. ADDRESS 1110 SpringSt., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Creation	23b. DATE 11-1-68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Washington San & Hospital	23d. LOCATION (City or Town) Takoma Park	(County) Mont.	(State) Md.
24. FUNERAL DIRECTOR J.D. Ruffcorn, 7600 Carroll Ave., Takoma Park, Md.	ADDRESS	25a. REC'D BY REGISTRAR NOV 4 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

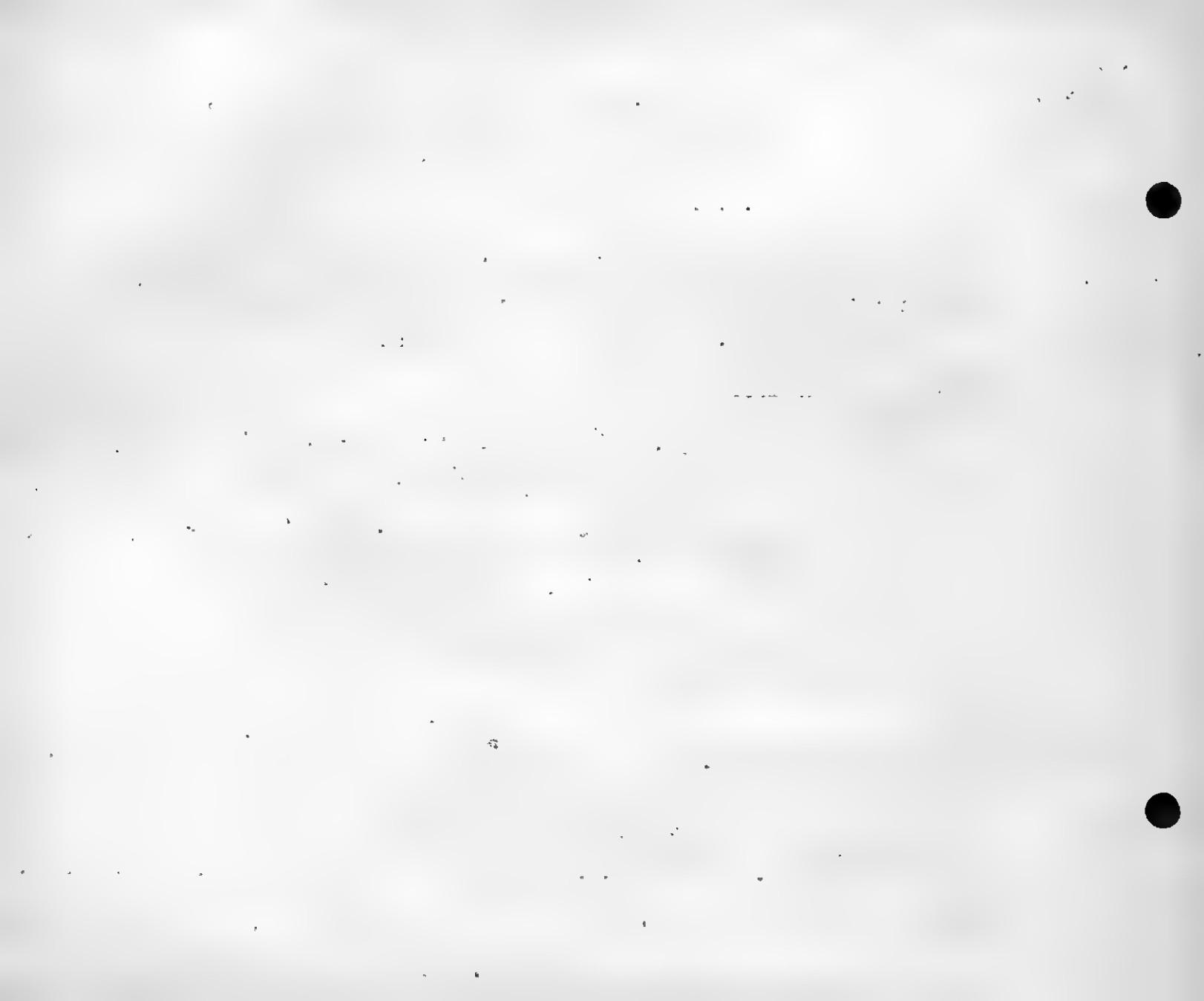
14548

14550

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First MARY	Middle A.	Last BOBZIEN	2a. DATE OF DEATH October Month 1, Day 1968	2b. HOUR 1pm
3. SEX Female	4. RACE White	5. DATE OF BIRTH June 19, 1893		6. AGE (In years last birthday) 75	IF UNDER 1 YEAR MONTHS 3 DAYS 22 IF JUNIOR 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Minnesota	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5426 Amberwood Lane		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) Maryland	13c. CITY OR TOWN Montgomery	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5426 Amberwood Lane		
14. FATHER'S NAME First Charles	Middle T.	Last Anson	15. MOTHER'S MAIDEN NAME Elizabeth	Middle	Last Fagan
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. -----	17. INFORMANT (Daughter) Mrs. James H. Doyle, same item # 13	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Collapse</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause <i>11/21</i> <i>Excessive Heart Failure</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sev. hours</i>		
(b) <i>Arterosclerotic Heart Disease</i> <i>many yrs</i> DUE TO, OR AS A CONSEQUENCE OF last. <i>Generalized arteriosclerosis</i>			<i>sev. weeks</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH-BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 7, 1968</i> , to <i>Oct 1, 1968</i> , that (I) (we) lost saw the deceased alive on <i>Sept 1, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>George H. Mitchell</i>	DEGREE ATTENDING PHYS.	22c. DATE SIGNED <i>10/11/68</i>	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	<input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) George H. Mitchell, M.D.	22e. ADDRESS 11125 Rockville Pike, Rockville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/5/68	23c. NAME OF CEMETERY OR CREMATORIAL Holy Hope	23d. LOCATION (City or Town) Tucson,	(County) Arizona	(State)
24. FUNERAL DIRECTOR Tyson Wheeler	ADDRESS 1331 Rockville Pike, Rock.	25a. REC'D BY REGISTRAR McDA 10CT 3 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

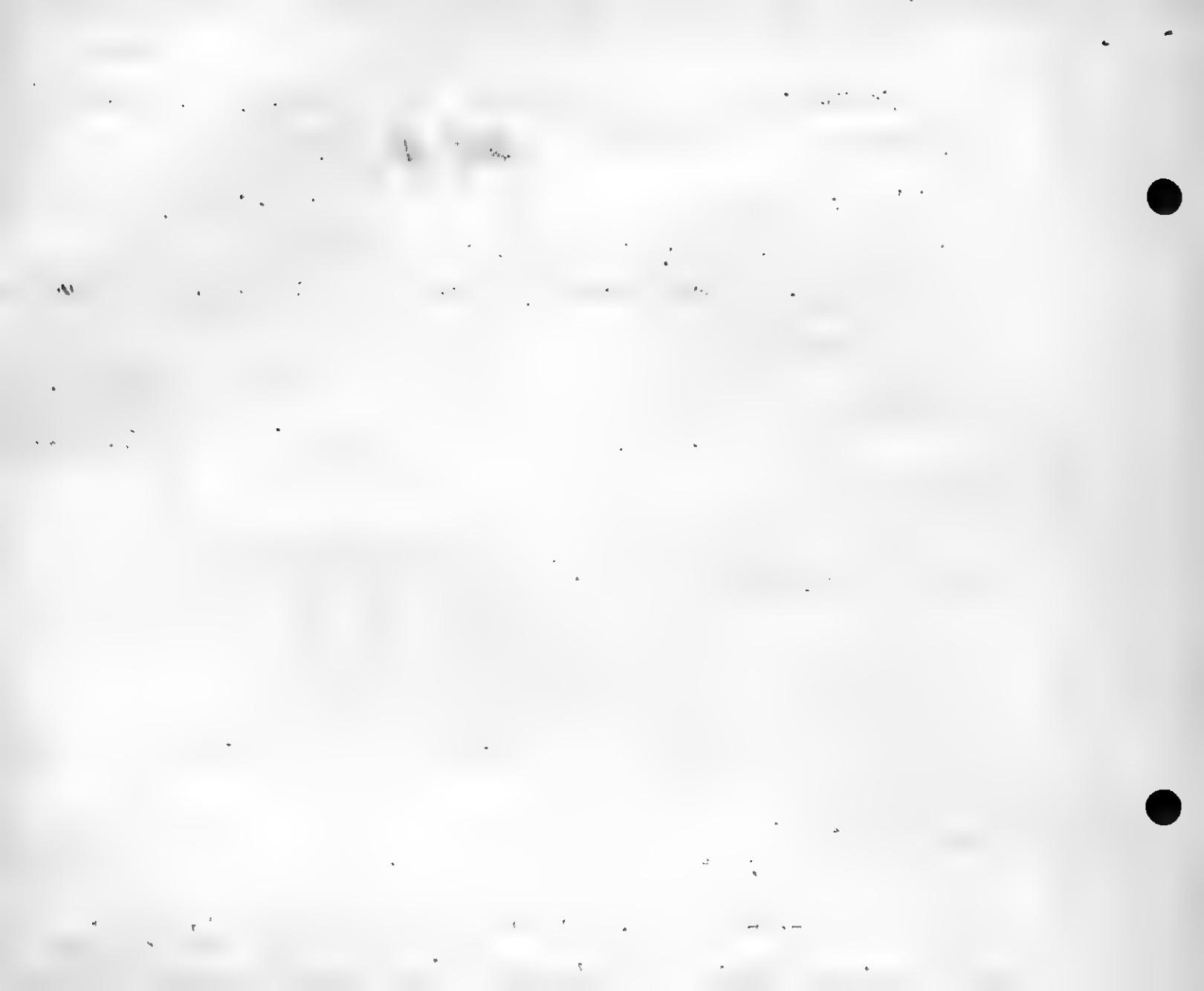
CERTIFICATE OF DEATH

14551

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign and date this certificate, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign and date this certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2. DATE OF DEATH Month	2b. HOUR 10 AM
MARY		BOCSI		OCTOBER	5 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday) 84	F UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS HOURS MIN
FEMALE	CAUCASIAN	DEC 1, 1883	YRS.	MONTHS	MD.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH		
HUNGARY	Hungary		MONTGOMERY		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
SILVER SPRING	HOLY CROSS HOSPITAL			Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	12b. KIND OF BUSINESS OR INDUSTRY	
MARYLAND	MONTGOMERY KENSINGTON	NO	5013 PRUDI DRIVE		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	Address
Joseph Ferenc				Unknown	Same as Item 13.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (if yes give war or dates of service)	17. INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No	None	son Robert Bocsi	8 months		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)).					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Carcinoma of GI Tract					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
59X					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
Atherosclerotic H.D. Rheumatoid Arthritis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 20</u> , 1968, to <u>Oct 20</u> , 1968, that (I) (we) last saw the deceased alive on <u>Oct 20</u> , 1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	22c. DATE SIGNED		
H. C. MAGARSKI		500 Edmonstone Dr., Rockville	10/20/68		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town)	(County)	(State)
Burial	10-23-68	St. Charles Cemetery	Twin Rocks, Penna.		
24. FUNERAL DIRECTOR	ADDRESS		25a. REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY, Bethesda, Maryland			OCT 24 1968	Charles Judge	

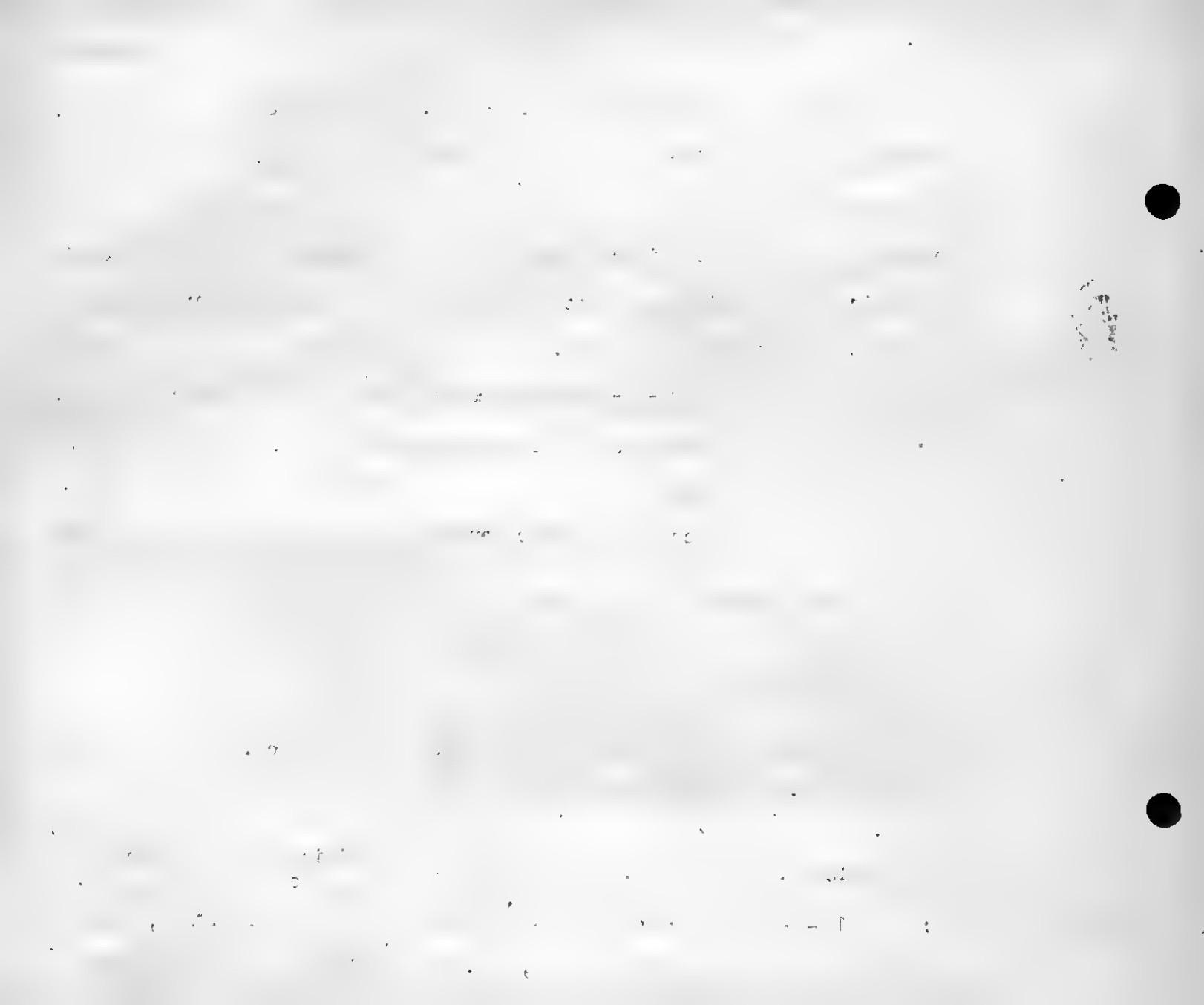


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)				First Joseph	Middle Anthony	Last Bono, Jr.	2a. DATE OF DEATH Month October	Day 4	Year 1968	2b. HOUR AM 9:45				
3 SEX Male		4 RACE White		5 DATE OF BIRTH 12 June 1942			6. AGE (in years last birthday) 26 yrs.		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS HOURS 0		MIN 0	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery						
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Teacher			12b. KIND OF BUSINESS OR INDUSTRY Education						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Virginia		13b. CITY OR TOWN Fairfax		13c. CITY OR TOWN Merrifield		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2822 Juniper Street						
14. FATHER'S NAME Joseph		First Anthony		Middle Bono, Sr.	Last	15. MOTHER'S MAIDEN NAME Antoinette		Middle Picard						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16b. SOCIAL SECURITY NO 225-58-9726		17. INFORMANT Bethesda, Maryland			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days							
				17. INFORMANT The Medical Records, The Clinical Center.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														
PART I. DEATH WAS CAUSED BY														
IMMEDIATE CAUSE (a) Hepatorenal failure, etiology unknown														
DUE TO, OR AS A CONSEQUENCE OF														
(b) Sepsis														
DUE TO, OR AS A CONSEQUENCE OF														
(c) Acute myelocytic leukemia														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 26 Sept., 1968 , to 4 Oct., 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4 October 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.														
22b. SIGNATURE <i>Brian Goodell M.D.</i>														
22d. PHYSICIAN'S NAME (Type) Brian W. Goodell, MD.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.												
23a. BURIAL, CREMATION BURIAL <input checked="" type="checkbox"/>		23b. DATE 10-7-68		23c. NAME OF CEMETERY OR CREMATORIUM Rockbridge Memorial			23d. LOCATION (City or Town) RFD 4 Lexington, Virginia		(County) (State)					
24. FUNERAL DIRECTOR AMOLE FUNERAL HOME		ADDRESS BUENA VISTA, VA.			25a. RECD BY REGISTRAR OCT 15 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14553

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
<i>VIRGINIA B. H.</i>		<i>BOSWELL</i>		<i>OCTOBER 8 1968</i>		<i>1:40 AM</i>
3. SEX <i>F</i>		4 RACE <i>W</i>	5. DATE OF BIRTH <i>11/22/89</i>		6. AGE (In years last birthday) <i>78</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>NY</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONT GOMERY</i>
10. CITY OR TOWN OF DEATH <i>SILVER SPRING, MD.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>ENTERTAINMENT HOSPITAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>SECRETARY</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>chippewa amusement</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13c. CITY OR TOWN <i>Wheaton, MD.</i>	13d. INSIDE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>2145 Wheaton Place</i>		
14. FATHER'S NAME First <i>Barrie Brooks Hopkins II</i>		Middle <i>Caroline</i>	Last <i>Ellie</i>	15. MOTHER'S MAIDEN NAME First <i>Caroline</i>	Middle <i>Ellie</i>	Last <i>Ellie</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>578-42-2450</i>	17. INFORMANT <i>Kirvington Stans</i>	Address <i>2315 Patches Rd Lanham, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pneumonia</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Anemia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>last 493x</i>		DUE TO, OR AS A CONSEQUENCE OF (c)		Months		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus - ARTHRITIS of Spine General arteriosclerosis</i>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>fall</i>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Office Building, ETC.</i>	21f. LOCATION Street or R.F.D. No. <i>4115 Colie Dr.</i>	City or Town <i>Wheaton</i>	County <i>Maryland</i>	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/1/68</i> to <i>10/8/68</i> , that (I) (we) last saw the deceased alive on <i>10/8/68</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did-not) view the body after death.						
22b. SIGNATURE <i>R. J. Benack MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>10/8/68</i>
22d. PHYSICIAN'S NAME (Type) <i>R. J. Benack MD</i>		22e. ADDRESS <i>4115 Colie Dr. Wheaton, MD.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 10-9-68</i>	23b. DATE <i>10-9-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Feliciana Cemetery</i>		23d. LOCATION (City or Town) <i>Colona, Maryland</i>	(County) <i>Montgomery Co.</i>	(State) <i>MD</i>
24. FUNERAL DIRECTOR <i>Mr. Jeldson D.H.</i>	ADDRESS <i>Dawson, MD.</i>	25a. REC'D BY REGISTRAR <i>Oct 14 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14554

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First JEAN	Middle GIBSON	Last BOTELER	2a. DATE OF DEATH Month 10	Day 23	Year 68	2b. HOUR 10:30 A.M.
3 SEX Female	4. RACE White		5. DATE OF BIRTH Feb. 27, 1909	6. AGE (In years last birthday) 59 yrs		F. JNR 1 YEAR MONTHS 0	I.F. UNDER 24 HRS. DAYS 0
7a. BIRTHPLACE (State or foreign country) Pa.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. USUAL RESIDENCE (Where deceased lived, if institut on-Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Sp.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 522 Margaret Drive			
14. FATHER'S NAME Joseph	First p.	Middle Gibson	15. MOTHER'S MAIDEN NAME Elva			Middle Jennings	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Robert Boteler	Address 522 Margaret Dr. Silver Spring		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left hemothorax (2500 ml) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) Ruptured dissecting thoracic aortic aneurysm. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) 451							
19a. DATE OF OPERATION 451	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 1964, to 23 Oct, 1968, that (I) (we) last saw the deceased alive on 20 Oct 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ira N. Tublin		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/23/68		
22d. PHYSICIAN'S NAME (Type) Ira N. Tublin		22e. ADDRESS 800 Pershing Dr., Sil. Spr., Md. 209					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 0-28-1968	23c. NAME OF CEMETERY OR CREMATORIAL St. Marks Cemetery	23d. LOCATION (City or Town) Frederick County, Md.		(County)	(State)	
24. FUNERAL DIRECTOR John G. Glen Carter 1101 1st St. E. Pumphrey, Ga. Avenue		ADDRESS Sil. Spr. Md.	25a. RECD BY REGISTRAR OCT 30 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			
30M REV 1/68			DATE				

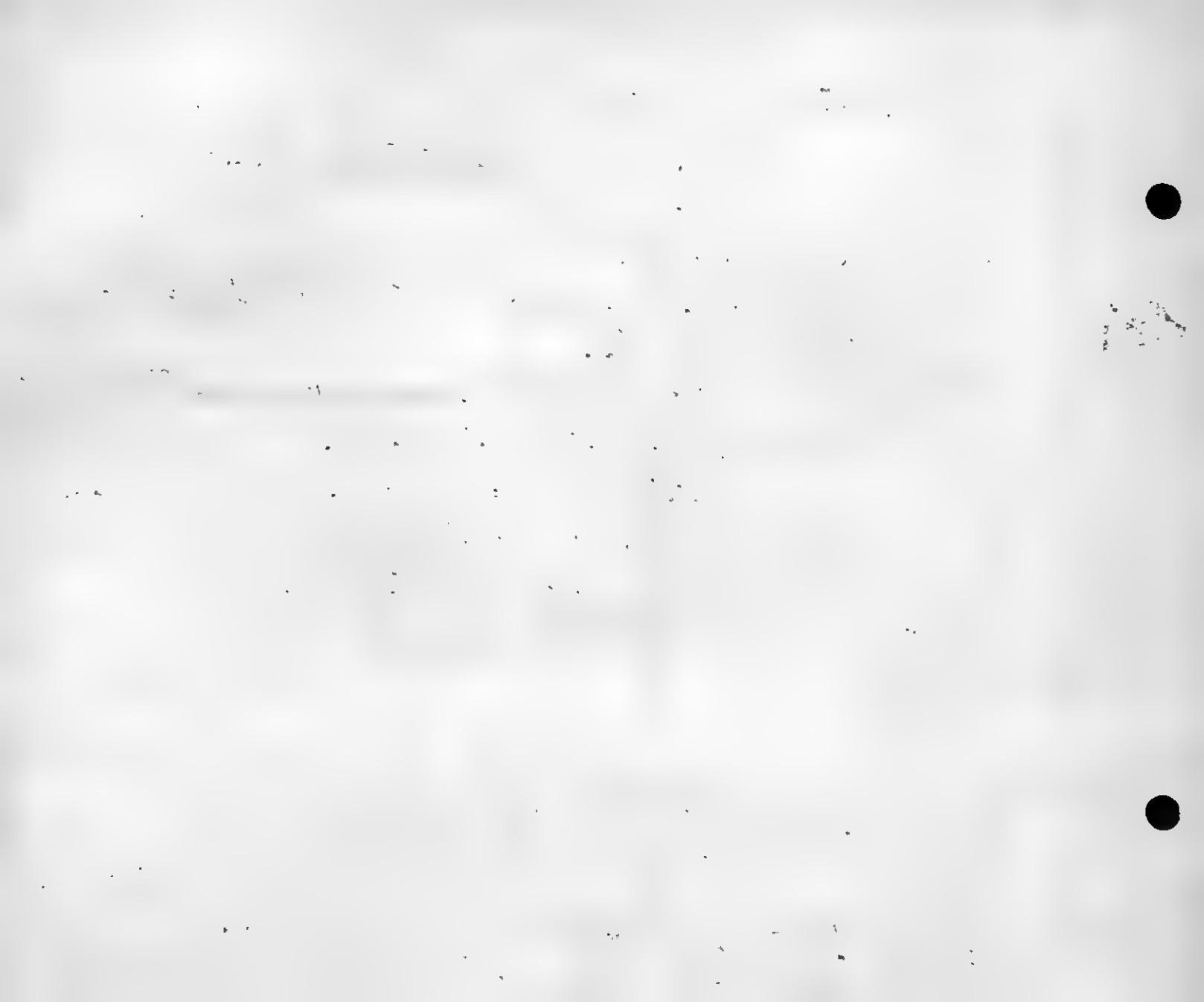


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 4 may be retained by the hospital or attending physician. To Funeral Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		14547		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH										14555	
1. DECEASED NAME (Type or print)		First <u>Ellenra</u>		Middle <u>Infrance</u>		Last <u>Bowman</u>		2a. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>68</u>		2b. HOUR Hours <u>8:30 A.M.</u>					
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>2-9-1902</u>		6. AGE (In years last birthday) <u>66 yrs</u>		7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u>	
10. CITY OR TOWN OF DEATH <u>Kensington</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or street address) <u>Kensington Gardens Sanitorium</u>		12a. USUAL OCCUPATION (Kind of work done during most at working life, even if retired) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>									
13a. USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE <u>Maryland</u>		13c. CITY OR TOWN <u>Wheaton</u>		13d. INSIDE CITY, MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>1832 Huggings Drive</u>									
14. FATHER'S NAME First <u>Unknown</u> Middle <u>Morgan</u> Last		15. MOTHER'S MAIDEN NAME First <u>Unknown</u> Middle <u></u> Last													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>415-50-0009</u>		17. INFORMANT <u>John E. Bowman</u>		Address <u>Rockville, Md.</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sequel vascular catastrophe</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>Hyperkinetic cardiovascular disease</u>		DUE TO, OR AS A CONSEQUENCE OF <u>Diabetes Mellitus</u>				Address <u>Unknown</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pulmonary tuberculosis (Healed)</u>															
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>3/18</u> , 19 <u>66</u> , to <u>10/11</u> , 19 <u>68</u> , that (I) (was) lost saw the deceased alive on <u>9/16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (not) view the body after death															
22b. SIGNATURE <u>M. S. Mapeloff</u>		22c. DATE SIGNED <u>10/1/68</u>		2d. DEGREE <u>MD</u>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (Type) <u>M. S. Mapeloff</u>		22e. ADDRESS <u>10620 Ga. Ave. Silver Spring Md.</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-15-1968</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Frederick Memorial Park</u>		23d. LOCATION (City or Town) <u>Frederick</u>		(County) <u>Maryland</u>							
23e. FUNERAL DIRECTOR <u>C. Glen Carter</u>		ADDRESS <u>8434 Ga. Ave. Md.</u>		23a. REC'D. BY REGISTRAR <u>OCT 21 1968</u>		23b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									
23f. Crematory <u>Warner E. Pumphrey, Inc.</u>				DATE											



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

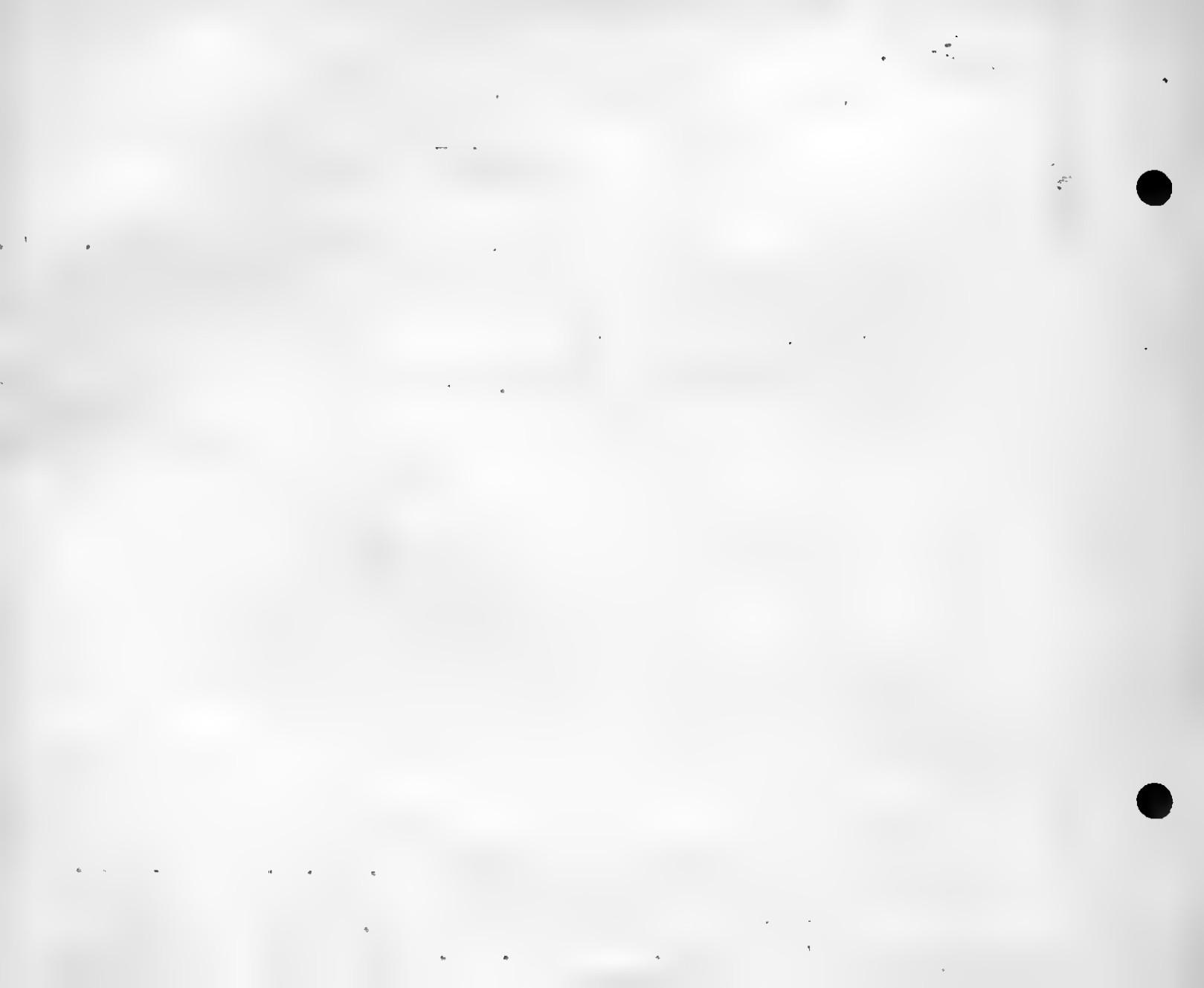
CERTIFICATE OF DEATH

14556

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First James	Middle Edmund	Last Brady	2a. DATE OF DEATH Month 10	Day 23	Year 68	2b. HOUR 7 A.M.		
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH 12-23-1908		6. AGE (In years last birthday) 59		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN. 0
7a. BIRTHPLACE (State or foreign country) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? United States		B MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1834 East West Highway		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13c. CITY OR TOWN Montgomery		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1834 East West Highway				
14. FATHER'S NAME Frank A.		First Frank	Middle A.	Last Brady	15. MOTHER'S MAIDEN NAME Grace		Middle Grace	Last Cuttle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO N.W. II		17. INFORMANT Mrs. Margaret B. Brady, Wife, same as item 15		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause 4701		DUE TO, OR AS A CONSEQUENCE OF Coronary Occlusion - Probable				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute				
(b) Arteriosclerotic Heart Disease		DUE TO, OR AS A CONSEQUENCE OF Hypertensive vascular disease				10 years				
(c) Diabetes Mellitus, Coronaria of Colon (resected)						10+ years				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from June 1967 , to 10-22-1968 , that (I) (we) last saw the deceased alive on 10-21-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Alan M. Weintraub, M.D.		DEGREE M.D.	ATTENDING PHYS A	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 10-23-68				
22d. PHYSICIAN'S NAME (Type) Alan M. Weintraub, M.D.		22e. ADDRESS 5201 Conn. Ave. N.W., Wash., D.C.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-25-1968		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.		23d. LOCATION (City or Town) Baltimore, Maryland				
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS 5130 Wisc. Ave.		25a. RECEIVED BY REGISTRAR DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14557

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1 DECEASED NAME (Type or print)	First ALBERT	Middle W.	Last BRAND	2a. DATE OF DEATH 10 Month 6 Day 08 Year	2b. HOUR 12 30 P.M.
3 SEX Male	4. RACE Wh.		5. DATE OF BIRTH 12/21/91	6. AGE (In years last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired	12b. KIND OF BUSINESS OR INDUSTRY Hedin Drive		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Sp	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 9731 Hedin Drive	
14. FATHER'S NAME First William	Middle BRAND	15. MOTHER'S MAIDEN NAME First — UNK —	Middle	Lost	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 577 03 6604	17 INFORMANT A.W. BRAND	Address # 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Dis; DUE TO, OR AS A CONSEQUENCE OF Severe Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) Myocardial Fibrosis; Complete Thrombotic DUE TO, OR AS A CONSEQUENCE OF Occlusion Of Anterior Descending (c) Branch Of L Coronary Artery					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) Pulmonary Edema					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)	21f LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 10-6, 1968, to 10-6, 1968, that (I) (we) last saw the deceased alive on 10-6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J. Frederick Barr MD</i>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10-6-68	
22d. PHYSICIAN'S NAME (Type) J. FREDERICK BARR	22e ADDRESS 4500 College Ave, College Park, Md.				
23a. BURIAL, CREMATION, REMOVAL, ETC. BURIAL	23b. DATE 10/9/1968	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven	23d. LOCATION (City or Town) Silver Spring	(County) Md	(State)
24. FUNERAL DIRECTOR W.H. Tallman	ADDRESS 4748 Wisconsin Ave NW	25a. REG'D BY REGISTRAR OCT 9 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A 162 30M REV 1/68					

20 22 24

§ 12a. 1

20 22 24

X X

20 22 24 26 28 30 32 34

20 22

20 22 24

20 22 24 26 28 30 32 34

20 22 24 26 28 30 32 34
20 22 24 26 28 30 32 34
20 22 24 26 28 30 32 34
20 22 24 26 28 30 32 34

20 22 24 26 28 30 32 34

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14550

CERTIFICATE OF DEATH

14558

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First FLORENCE	Middle DOROTHY	Last BRANDT	2a. DATE OF DEATH Oct. Month 27 Day 68 Year	2b. HOUR 7.15PM
3. SEX FEMALE	4 RACE CAUC	5. DATE OF BIRTH JAN 13, 1886		6. AGE (in years last birthday) 82 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY COUNTY, MD.		
10. CITY OR TOWN OF DEATH SILVER SPRING, MD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FAIRFIELD NURSING HOME	12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) MWF & MOTHER		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased admission) STATE ROCKVILLE MD	lived, if 'institut on Residence before 13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 604 MCINTYRE RD.	
14. FATHER'S NAME First DAVID	Middle SOWAHL	Lost	15. MOTHER'S MAIDEN NAME First MORSE	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO 102-05-6930-4	17. INFORMANT Mrs. Hazel Deriso Some item # 135	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week			
DUE TO, OR AS A CONSEQUENCE OF Arthritis DUE TO, OR AS A CONSEQUENCE OF Diabetes & Congestive heart failure long standing (gen)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Feb. 22, 1967, to Oct. 1, 1968, that (I) (we) last saw the deceased alive on 10/24/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (d d'not) view the body after death.					
22b. SIGNATURE Raymond T. Benack		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10/27/68		
22d. PHYSICIAN'S NAME (Type) Raymond T. Benack	22e. ADDRESS 4115 Collie Drive, Silver Spring, Md.				
23a. BURIAL CREMATION, REMOVAL (specify) Burial	23b. DATE 10/31/68	23c. NAME OF CEMETERY OR CREMATORIAL Evergreen	23d. LOCATION (City or Town) Brooklyn, NY	(County)	(State)
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home	ADDRESS Rockville Rockville, Md.	25a. RECD BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE OCT 30 1968		



14551

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14559

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in at the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dpt. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>Emma</i>	Middle <i>H</i>	Last <i>Troyton</i>	2a. DATE OF DEATH Month <i>Oct.</i>	Day <i>7</i>	Year <i>1968</i>	2b. HOUR <i>9 1/2 M</i>
3 SEX <i>female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>1/11/22</i>		6. AGE (in years last birthday) YRS. <i>46</i>	IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 24 HRS HOURS <i>0</i>
a BIRTHPLACE (State or foreign country) <i>Virginia</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>				
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Louis</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Cashier</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Grocery store</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Mont. Bethesda</i>	13c CITY OR TOWN <i>Bethesda</i>	3d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>10104 - Tropicana Ave.</i>			
14. FATHER'S NAME First <i>John Wright</i>	Middle	Last	15. MOTHER'S MAIDEN NAME First <i>Myrtle Campbell</i>		Middle	Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b SOCIAL SECURITY NO <i>Unknown</i>	17 INFORMANT <i>Evelyn J. Troyton</i>	Address <i>32nd St. Apt. 1</i>				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Generalized calcifications</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>hypertension, rt. ovary</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
↓							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1.</i>							
19a DATE OF OPERATION <i>4/30/68</i>	19b CONDITION FOR WHICH OPERATION WAS PERFORMED <i>hypertension</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING (If either, notify medical examiner) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) <i>offce building, etc.</i>	21f LOCATION Street or R.F.D. No. <i>Street</i>	City or Town <i>Montgomery</i>	County <i>Montgomery</i>	State <i>Md</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>4/30</i> , 19 <i>68</i> , to <i>present</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/15</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>I.L. Marks, M.D.</i>							
22d PHYSICIAN'S NAME (Type) <i>I.L. MARKS, M.D.</i>	DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22e ADDRESS <i>320 UNIVERSITY BLVD. E.</i>	22f. DATE SIGNED <i>10/8/68</i>				
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE <i>10-11-68</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Lone Star Cemetery</i>	23d LOCATION (City or Town) <i>Covington</i>	(County) <i>Virginia</i>	(State) <i>Md</i>		
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	25a. REC'D BY REGISTRAR DATE <i>OCT 11 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



FOR STATE
HEALTH DEPT.

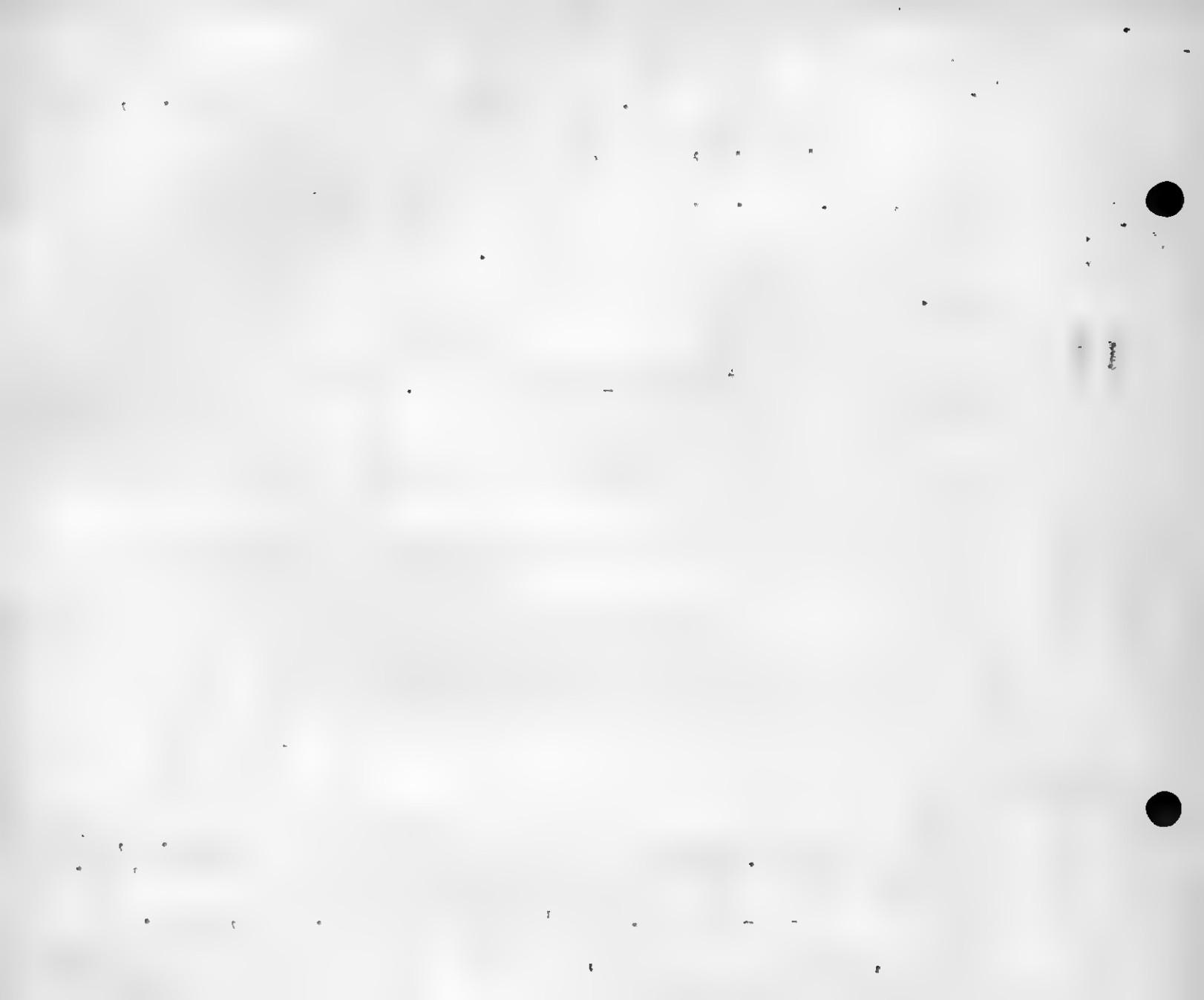
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 Items 1, 15 & 17
2 MARYLAND STATE DEPARTMENT OF HEALTH
3 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
4 FilmG405 10/17/68 kic

5 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 14560

1 DECEASED NAME (Type or Print)		First	Middle	Last	Brennan	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month Day Year Oct. 7, 1968	2b. HOUR M
KATHERINE		D.	BRENNAN		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year Oct. 5 1968		2d. HOUR P
3 SEX Female	4. RACE Cauc.	5 DATE OF BIRTH Aug. 18, 1889	6. AGE (In years last birthday) 79 yrs					
7a. BIRTHPLACE (State or foreign country) Boston, Mass.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5480 Wisconsin Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Mass.		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMIT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 18 High Street		
14. FATHER'S NAME Peter Donovan		First	Middle	Last	15. MOTHER'S MAIDEN NAME Unknown	First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 578-44-9427		17. INFORMANT Edward T. Brennan		ADDRESS Brennan		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Insufficiency acute -</i> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Generalized Arterialclerosis -</i> DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i> years.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball -</i>		JOHN G. BALL		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Oct. 7, 1968		
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial								
23b. DATE 10-11-68		23c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		23d. LOCATION (City or Town) No. Salem, Mass.		(County) (State)		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15ME (5) 10M REV. 1/68								

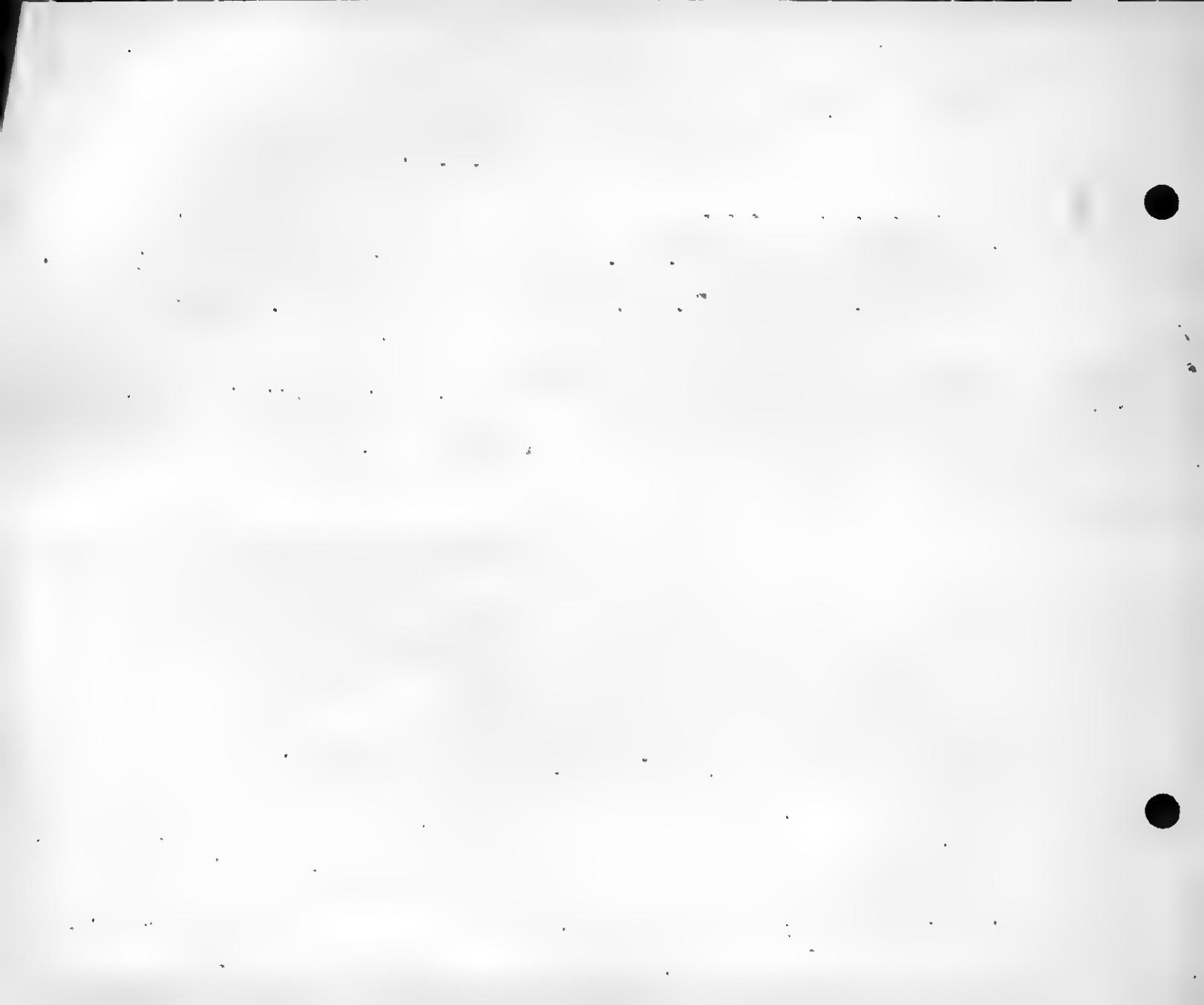


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

16553		14561				
1. DECEASED-NAME (Type or print)		First <i>Thomas</i>	Middle (N.M.)			
Last <i>Brennan</i>		2a. DATE OF DEATH Month 10 Year 1968 2b. HOUR 4:50 AM				
3. SEX <i>Male</i>		4. RACE <i>White</i>	5. DATE OF BIRTH <i>Jan. 18, 1901</i>			
7a. BIRTHPLACE (State or foreign country) <i>Wash. D. C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. San. & Hospital</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13c. CITY OR TOWN <i>Chillum</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Carpenter -</i>			
13b. COUNTY <i>Pr. Geo.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>1307 Ray Road</i>			
14. FATHER'S NAME First <i>John</i>		Middle <i>Brennan</i>	15. MOTHER'S MAIDEN NAME First Middle Last <i>Maria Hunter</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>578-03-6394</i>	17. INFORMANT <i>Evelyn C. Brennan</i>			
			Address <i>1307 Ray Road Chillum, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>492X</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Emphysema</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i></i>				
		DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>5271</i>						
19c. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) <i></i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i></i>	21f. LOCATION Street or R.F.D. No <i></i>	City or Town <i></i>	County <i></i>	State <i></i>
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 11, 1968</i> , to <i>Oct 21, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 21, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Boris Rabkin, MD</i>		22c. DEGREE <i>MD.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	DATE SIGNED <i>Oct 22, 1968</i>
22d. PHYSICIAN'S NAME (Type) <i>Boris Rabkin, MD</i>		22e. ADDRESS <i>1019 Univ. Blvd. East</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i></i>		23b. DATE <i>10-25-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ht. Lincoln Cemetery</i>	23d. LOCATION (City or Town) <i>Prince Georges, Md.</i>	(County) <i></i>	(State) <i></i>
24. FUNERAL DIRECTOR <i>C. Glen Carter</i>		ADDRESS <i>Warren E. Pumphrey, Inc. 8134 Ga. Ave. S.S. Md.</i>		25a. REC'D BY REGISTRAR <i>OCT 25 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



14554

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS 301 W. PRESTON STREET BALTIMORE, MARYLAND 21201 14562

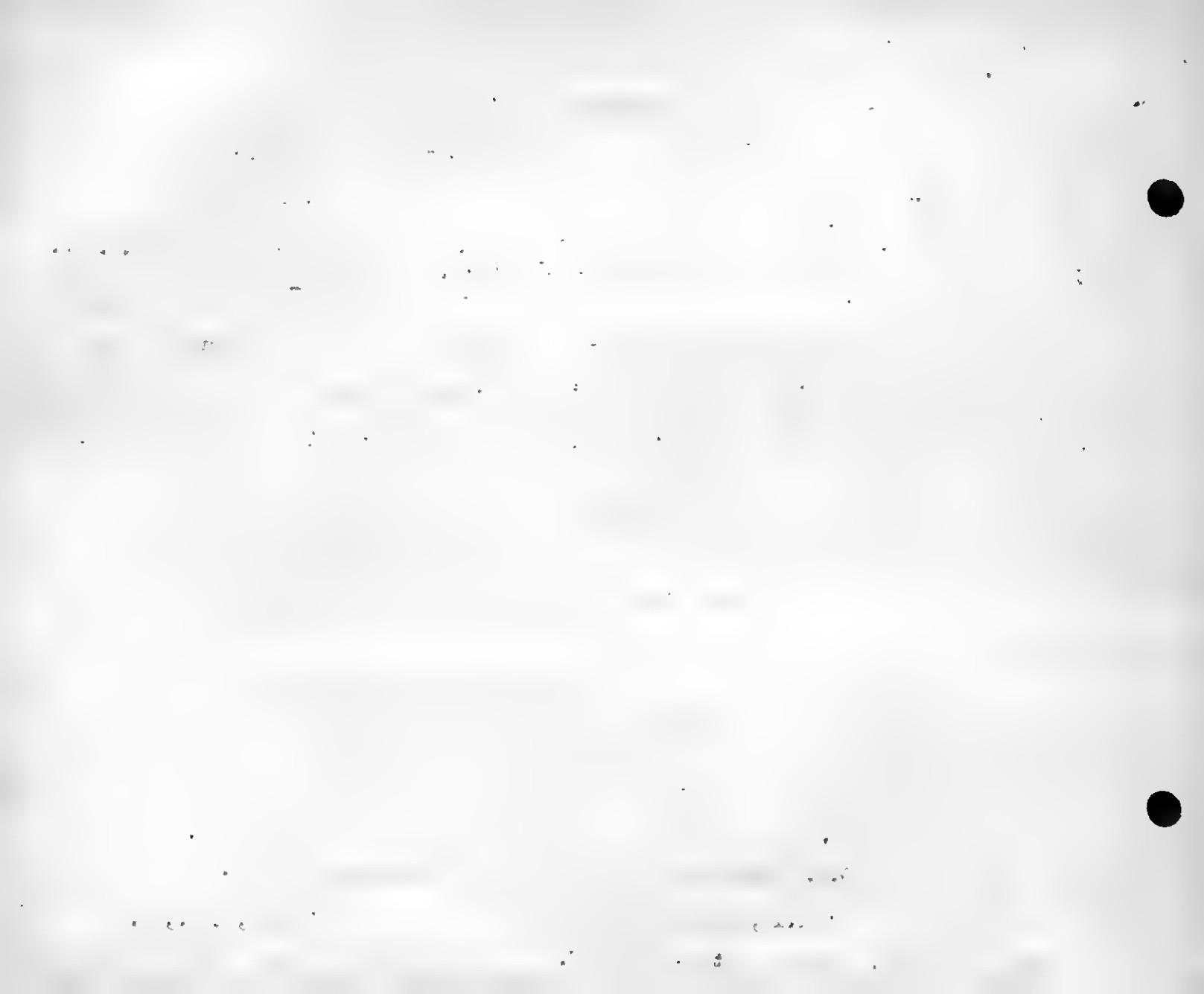
Item#8, Film G105 10/14/68 km

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please do not file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)	First Edward	Middle Thomas	Last Brooke	2a. DATE OF DEATH Month Oct.	Day 9	Year 68	2b. HOUR P 3:30M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 10-10-79		6. AGE (In years last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Sandy Spring	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Md. Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Accountant		12b. KIND OF BUSINESS OR INDUSTRY U.S.Gov.				
13a. USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) STATE Md.	13b. COUNTY Montgomery	Sandy Sp.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER -				
14. FATHER'S NAME First Roger	Middle Brooke	15. MOTHER'S MAIDEN NAME Louisa	Thomas	Middle Thomas	Last Brooke			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Unknown	16b. SOCIAL SECURITY NO. 579-60-8583	17. INFORMANT Nursing Home Records	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>July, 1964</u> , to <u>10-9-1968</u> , that (I) (we) last saw the deceased alive on <u>10-8-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>G.F. Sengstack MD</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>10-9-68</u>			
22d. PHYSICIAN'S NAME (Type) G.F. Sengstack		22e. ADDRESS Silver Spring, Md.						
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 12, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Woodside		23d. LOCATION (City or Town) Brinklow, Mont., Md. (County) (State)			
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.				ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 11 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14563

14555

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. If either the physician or the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Dovie C.</i>	Middle <i>C.</i>	Last <i>BROOKS</i>	20. DATE OF DEATH Month 10 Day 3 Year 1968	2b HOUR 10:45A.M.
3. SEX <i>Female</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>1-5-1894</i>		6. AGE (In years last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Va.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>			
10 CITY OR TOWN OF DEATH <i>Wheaton</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>University Nursing Home</i>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>MORTICIAIN</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Wash. D.C.</i>	13b. COUNTY <i>D.C.</i>	13c. CITY OR TOWN <i>Washington</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>525 21st St. N.E.</i>		
14 FATHER'S NAME <i>JAMES PIETERS</i>	First Middle Last	15 MOTHER'S MAIDEN NAME First <i>JOSEPHINE ?</i>		Middle Last		
16a. WAS DECEASSED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Or unknown <i>unknown</i>	16b. SOCIAL SECURITY NO. <i>579-05-9645</i>	17. INFORMANT <i>GARFIELD TERRANCE LILLIAN SUTTON</i>	Address <i>11TH ST. AVE. N.W.</i>			
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>	DUE TO, OR AS A CONSEQUENCE OF (b) <i>Obtuse Arteriosclerosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerosis</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>3300</i>						
19a. DATE OF OPERATION <i>3300</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>310</i> , 19 <i>68</i> , to <i>10/3</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/3</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Lawrence Cannaday, M.D.</i>		DEGREE ATTENDING PHYS.	22c. DATE SIGNED <i>10/3/68</i>	A MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) <i>LAWRENCE R. CANNADAY, M.D.</i>		22e. ADDRESS <i>3632 - GEORGIA AVE. N.W. D.C.</i>				
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>10-6-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>LINCOLN MEM.</i>		23d. LOCAT ON (City or Town) <i>SUITLAND MD.</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Brooks & Alley</i>	ADDRESS <i>1200 FLA AVE. N.W.</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 9 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P.M. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH										14564					
1 DECEASED NAME (Type or Print)		First			Middle		Last			2a DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b HOUR	
		GEORGE			FRANCIS		BROWN			<input type="checkbox"/>	10	27	1968	8:45P	
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (in years last birthday)	7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD	Month	Day	Year	2d HOUR	
Male	White	5-20-79			89 YRS	MONTHS	DAYS	HOURS	MIN	<input type="checkbox"/>	10	27	1968	9:05P	
7a. BIRTHPLACE (State or foreign (country))		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Washington, D.C.		United States								Montgomery					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a U.S. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY							
Silver Spring, Md		Montgomery Hospt.			Farmer			Farming							
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY			13c CITY OR TOWN	13d INSIDE CITY LIMIT?		13e STREET AND NUMBER							
Maryland		Montgomery			Silver Spring	YES <input type="checkbox"/> NO <input type="checkbox"/>		17710 New Hampshire Avenue							
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last						
		Charles	Walter	Brown	Sophia		C.								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown)		16b SOCIAL SECURITY NO			17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No		220-05-3280			Elsie J. - Wife		Brown, Sonel 710 N. H. Ave. S.S., Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last															
(b) Coronary artery heart disease DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?										
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County		State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (City, town or county)		22b. DATE SIGNED				
Belden R. Yeap MD											10/28/1968				
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE			23c NAME OF CEMETERY OR CREMATORIAL			23d LOCATION (City or Town)		(County)		(State)			
Burial		10-31-1968			Burtonsville Union Cemetery			Prince Georges, Md.							
24 FUNERAL DIRECTOR		C. Glen Carter			ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE						
John Carter		C. Glen Carter			8434 Ga Ave. S.S., Md.		OCT 31 1968		Charles Judge						
Mr. E. J. Murray, Inc.															



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14565

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First CHARLES	Middle BOWLES	Last BRUCE	2a. DATE OF DEATH		2b. HOUR			
							Month OCT	Day 9	Year 1968	Hour 5:20 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR			
MALE		Colored		8-10-12			56 YRS		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (State or foreign country) Kent's Store VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban			12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired) F-drink Co'y D.C.			12b. KIND OF BUSINESS OR INDUSTRY House Maint				
13a. US/JAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 210 Frederick Ave -				
14. FATHER'S NAME Richard		Middle BRUCE	15. MOTHER'S MAIDEN NAME Mary									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO		17. INFORMANT Irene May Bruce (u fe)		Address Rockville 210 Frederick Ave		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 410 7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
MEDICAL CERTIFICATE ON												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)								
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from Sept 26 - 1968 , to Sept 7, 1968 , that (I) (we) last saw the deceased alive on Sept 26 - 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE D.L. Bucy / SN Jones		22c. DEGREE ATTENDING PHYS.		22d. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. DATE SIGNED 10-9-68						
22d. PHYSICIAN'S NAME (Type) D.L. Bucy / SN Jones		22e. ADDRESS 809 Veirs Mill Rd Rockville										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-11-68		23c. NAME OF CEMETERY OR CREMATORIAL Kent's Store Cem.		23d. LOCATION (City or Town) KENT, S STORE, VA		(County)		(State)		
24. FUNERAL DIRECTOR		ADDRESS ROBERT L. SNOWDEN		25a. REC'D BY REGISTRAR DATE OCT 14 1968		25b. REC'D BY JUDGE Judge						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14566

14558

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Please send page 3 to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First AMELIA	Middle F.	Last BRUSH	2a. DATE OF DEATH Month 10	Day 30	Year 68	2b. HOUR 10:30 A.M.			
3. SEX F.		4 RACE W.	5. DATE OF BIRTH 5-16-09		6. AGE (In years last birthday) 59 yrs		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) ITALY		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONT.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife at 2110 Home		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1713 GRIDLEY LANE			
14. FATHER'S NAME First Frank		Middle Jeanne	Last Brush	15. MOTHER'S MAIDEN NAME First Pauline		Middle Petoya	Last Brush				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 578-07-1011		17. INFORMANT David Brush		Address 1713 Gridley Lane, Sil. Spr. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 2509								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Diabetes mellitus.											
DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes mellitus.											
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State							
22o. I certify that (I) (this hospital) attended the deceased from March 1968 to 30 Oct 1968 , that (I) (we) last saw the deceased alive on 30 Oct 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ira D. Tablin MD		DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 10/31/68					
22d. PHYSICIAN'S NAME (Type) Ira Tablin MD		22e. ADDRESS 800 Parshing Drive, Sil. Spr. Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Cremated		23b. DATE 11-1-1968		23c. NAME OF CEMETERY OR CREMATORIAL Catons Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring, Montg. Md.	
24. FUNERAL DIRECTOR Charles E. Punshay, P.C.		ADDRESS Sil. Spr. Md. 8434 Ga. Ave.		25a. REC'D. BY REGISTRAR Charles Judge		DATE NOV 7 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 407 MARYLAND STATE DEPARTMENT OF HEALTH
12-9-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12559

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14567

1. DECEASED NAME (Type or Print)	First	Middle	Last	2d. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
LILAH ANN BUCKLER				<input checked="" type="checkbox"/>	10	19	68	M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	F. UNDER MONTHS	YEAR DAYS	IF UNDER 24 HRS HOURS	MIN.	2d. HOUR
Fe	Cauc.	7-3-1968	-- yrs	3	16			M
7d. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH					
Md.	U.S.A		Montgomery					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park Wash. D.C.	Saints & Hosp							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY L.M. 15?	13e. STREET AND NUMBER				
Md.	Montg.	TAK. PK	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	209 HODGES LANE				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
Francis - D. Buckler				Patricia	King	Lamb-		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS					
No	NONE	HOSP. RECORDS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Infant caught head between crib frame and mattress</u> Due to, or as a consequence of Subdural and subarachnoid hemorrhage due to Intracranial Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Due to, or as a consequence of hemorrhage, cause undetermined (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 to 12 hours</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>924C</u>								
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. PM	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Infant caught head between crib frame and mattress						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21d. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home	21f. LOCATION Street or R.F.D. No City or Town Takoma Park Montg. Md.	County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Belden R. Reap</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town, County)			22b. DATE SIGNED <u>10/19/1968</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town)	(County)	(State)			
Burial 10-22-68		Asbury Methodist Cemetery	Arnold	Md.				
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE					
W.L. Chambers C	Silver Spring Md.	OCT 23 1968	Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14568

1				2a. DATE OF DEATH <u>OCT 3 1968</u>				2b. HOUR <u>10 AM</u>			
1. DECEASED NAME (Type or print) <u>ALEXANDER</u>				Last <u>BURAK</u>		2a. DATE OF DEATH Month <u>OCT</u> Doy <u>3</u> Year <u>1968</u>		2b. HOUR IF UNDER 24 HRS. MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN. <u>0</u>			
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <u>9-15-1875</u>		6. AGE (in years last birthday) <u>93</u> YRS		F. UNDER YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN. <u>0</u>			
7a. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY</u>		Md			
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>FAIRLAND NURSING HOME</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <u>STATE</u> <u>316 BEAUMONT RD</u>		13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER			
14. FATHER'S NAME <u>BTZALAIOL</u>		15. MOTHER'S MAIDEN NAME <u>NEHA</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO <u>579-16-7940</u>		17. INFORMANT <u>Morris Burak (son)</u>		Address <u>5002 3rd St., N.W.</u>		Wash., D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY.		days									
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>		days									
DUE TO, OR AS A CONSEQUENCE OF		days									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>Myocarditis</u>		days									
(b) <u>Influenza</u>		days									
DUE TO, OR AS A CONSEQUENCE OF		days									
(c) <u>Influenza</u>		days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
ARTERIOSCLEROTIC HEART DISEASE, BRONCHITIS, GENERALIZED ARTERIOSCLEROSIS		2b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		2d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2d. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/12 1968</u> , to <u>10/13 1968</u> , that (I) (we) lost sow the deceased alive on <u>10/13 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R.T. Benack</u>		DEGREE <input type="checkbox"/> ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10/13/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>R.T. Benack MD</u>		22e. ADDRESS <u>4115 Colie Dr. Wheaton</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>OCT 4, 1968</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Beth Shalom Cemetery</u>		23d. LOCATION (City or Town) <u>Hillside, Maryland</u>		(County)		(State)	
24. FUNERAL DIRECTOR <u>Donald M. Stein</u>		ADDRESS <u>232 Carroll St., N.W. Wash., D.C.</u>		25a. REC'D BY REGISTRAR <u>OCT 7 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
Hebrew Memorial Funeral Home											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please ~~sign~~ stamp carbon paper. It should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm equipment. Page 5 may be retained for your files.

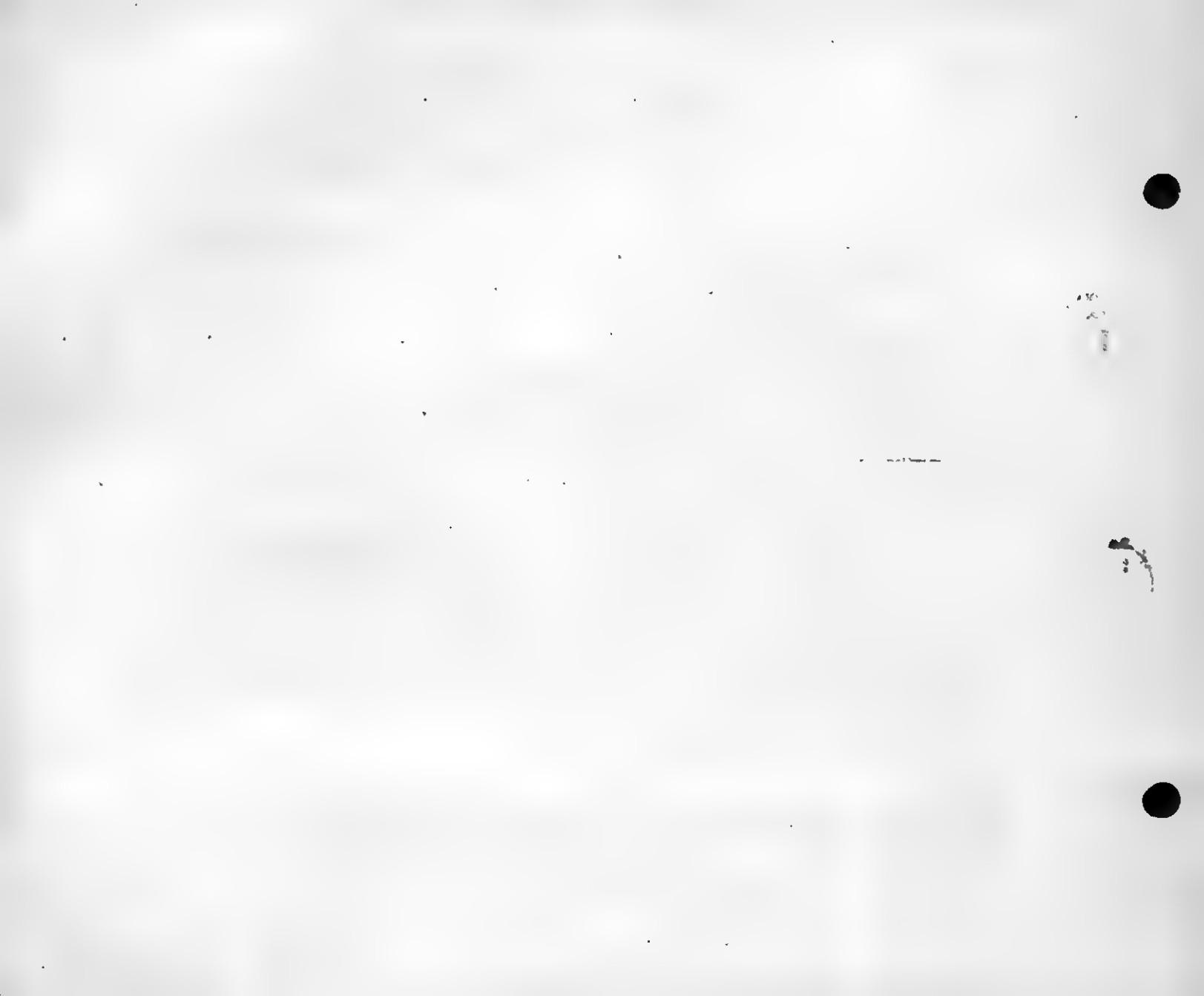
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14569

1 DECEASED NAME (Type or Print)		First <i>Lucy</i>	Middle <i>Benson</i>	Burdenette <i>Burdenette</i>			2a DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/>	Month Oct	Day 7	Year 1968	2b. HOUR 2 P.M.	
3 SEX <i>Fe.</i>	4 RACE <i>W-</i>	5 DATE OF BIRTH <i>Nov 23, 1888</i>	6 AGE IN YEARS last birthday <i>79 yrs</i>	F UNDER YEAR MONTHS <i> </i>	F UNDER 24 HRS DAYS <i> </i>	HOURS MIN <i> </i>	2c. DATE PRONONCED DEAD Month Oct			Day 7	Year 1968	2d HOUR 2 P.M.
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH - <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Gaithersburg</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Asbury Methodist Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Hyattstown</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER				
14. FATHER'S NAME First <i>James</i>		Middle <i>Benson</i>	Last <i> </i>	15. MOTHER'S MAIDEN NAME First <i>Mary</i>		Middle <i> </i>	Last <i>Jane Allinut</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16b. SOCIAL SECURITY NO (If yes give war or dates of service) <i>215-64-7402</i>		17. INFORMANT <i>Loring Methodist Home, Gaithersburg</i>			ADDRESS <i>911 Loring St., Gaithersburg, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per part I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>H.I.</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Bronchial Pneumonia.</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>				
Conditions, if any which gave rise to immediate cause (a) stating the underlying cause <i>Arteriosclerotic Heart Disease -</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic Heart Disease -</i>						Years - <i>years</i>				
DUE TO, OR AS A CONSEQUENCE OF <i>General Arteriosclerosis -</i>								Years. <i>years</i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>P.M.</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b)			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Hyattstown</i>		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner												
ACTUAL SIGNATURE <i>John D. Bell</i>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>Oct 7, 1968.</i>				
EXAMINER'S NAME (Type)					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
ADDRESS (Street, city, town, or county)												
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10-9-68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Hyattstown M.C. Cem.</i>			23d. LOCATION (City or Town) <i>Hyattstown Montg. Md.</i>		(County) <i>Montgomery</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>		ADDRESS <i>Ernest C. Gartner Gaithersburg Md.</i>		25a. REC'D BY REG STRK <i> </i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
DATE <i>OCT 10 1968</i>												



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14570

To HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Dr. Bell, recently visited & Examiner

14562		CERTIFICATE OF DEATH								
1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH	Month	Day	2b. HOUR			
Merle		McComas	Burdette	October 1 1968		5:45 P.M.				
3. SEX	4 RACE	5. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	White	7/25/12			56 yrs.					
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH					
Md.	U.S.				Montgomery					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Olney	Montgomery General			Painter						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	13e. STREET AND NUMBER				
Md.	Montg.	Damascus				27400 Ridge Rd.				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
Moody		McComas	Burdette	Ellen		G.	Kidwell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIA. SECURITY NO (If yes give war or dates of service)	17. INFORMANT			Address					
no	215-01-2828	Mrs Hazel Burdette, Damascus, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause						30 min.				
DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction						1 wk				
DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D.						2 years				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (This Hospital) attended the deceased from 8/30, 1968, to 10/1, 1968, that (I) (He) lost saw the deceased alive on 9/30, 1968, and that in (my) (His) opinion death occurred on the date and hour and from the causes stated above, (I) (He) (She) (did not) view the body after death.										
22b. SIGNATURE <i>James P. Kerr M.D.</i>		DEGREE ATTENDING PHYS.			MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 10/2/68		
22d. PHYSICIAN'S NAME (Type)		James P. Kerr, M.D.			22e. ADDRESS Damascus, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 4, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Lebanon			23d. LOCATION (City or Town) Nr. Damascus, Md.		(County) (State)	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		ADDRESS Olin L. Molesworth, Damascus, Md.			25a. REC'D BY REGISTRAR DATE OCT 3 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14571

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First BRUCE	Middle EARL	Lost BURKHOLDER	2d. DATE OF DEATH Month 10	Day 17	Year 68	2b. HOUR 4 PM			
3. SEX MALE		4 RACE CAUCASIAN	5. DATE OF BIRTH 6/25/60		6. AGE (in years from last birthday) 58 yrs		IF UNDER 1 YEAR MONTHS DAYS		F. UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN., & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Lab Tech		12b. KIND OF BUSINESS OR INDUSTRY		Md			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND		13c. CITY OR TOWN MONTGOMERY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6619 Poplar Ave.					
14. FATHER'S NAME First SIMON		Middle BURKHOLDER	Lost	15. MOTHER'S MAIDEN NAME First MARGARET		Last OHLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 191094796		17. INFORMANT HOSPITAL RECORDS		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		1621		Carcino Lung w/ Spinal (and metastases)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mo.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF							
		(c)		DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> Not at <input type="checkbox"/> work		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from March 1968 , to Oct 17, 1968 , that (I) (we) last saw the deceased alive on Sept 17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John W. Bierman		DEGREE ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED Oct 18, 68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 10/21/68		23c. NAME OF CEMETERY OR CREMATORIUM Cedra Grove Cemetery		23d. LOCATION (City or Town) MT Rainier		(County) MD		(State)	
24. FUNERAL DIRECTOR Valleys Funeral Home		ADDRESS MT Rainier - Maryland		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE					
				DATE OCT 21 1968							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

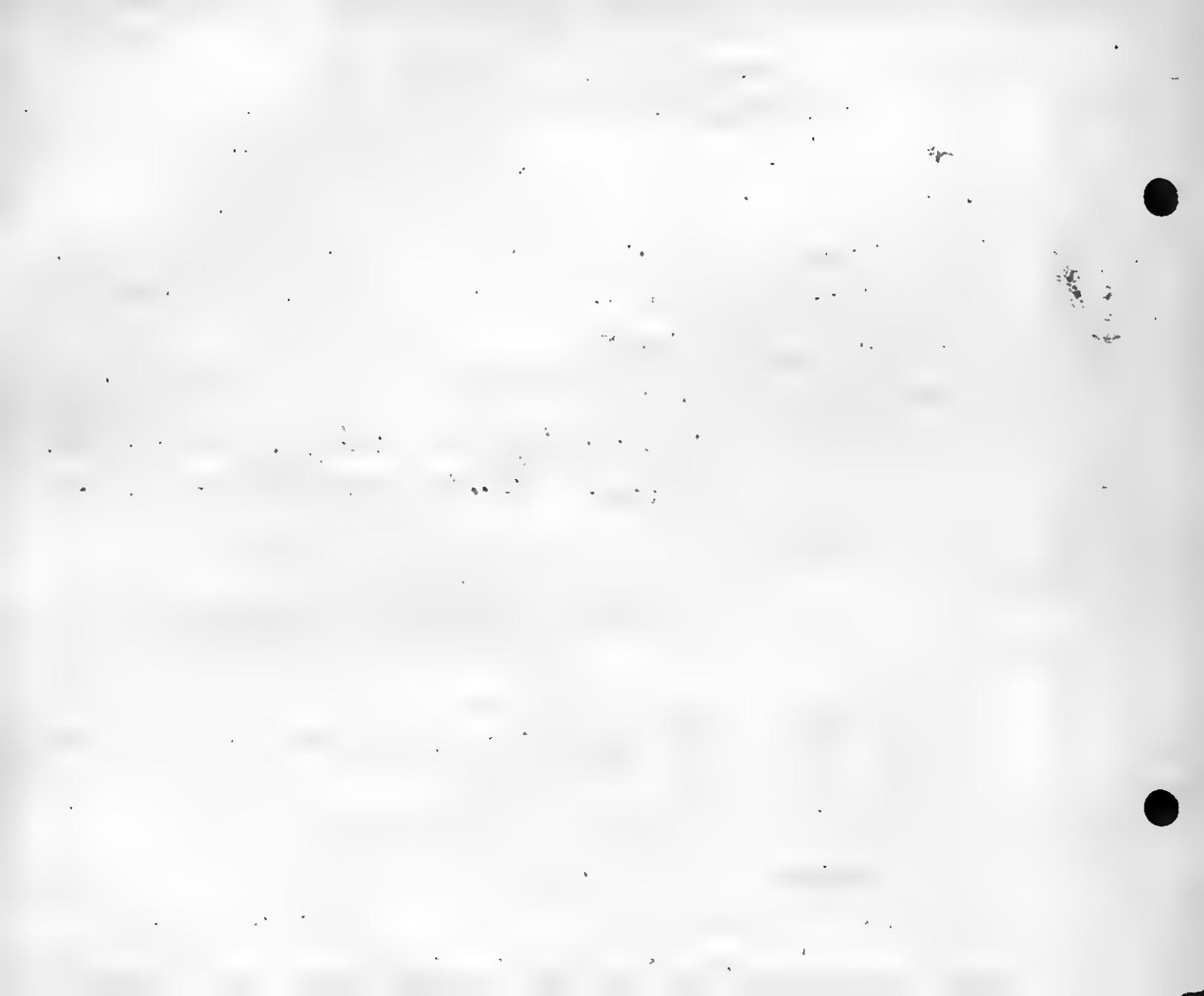
14572

16568

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-train permit. The please remove carbon paper, pages 1 and 2 from director, page 3 should be detached for use as the burial-train permit. The please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	20. DATE OF DEATH Month	Doy	Year	2b. HOUR 3:30 P.M.
NORMA P. BURNS						BURNS	Oct	15	68	
3. SEX <input checked="" type="checkbox"/> F		4. RACE Caucasian		5. DATE OF BIRTH 8-24-1895		6. AGE (In years last birthday) 73 yrs.		If under 1 year months days hours m.n.		
7a. BIRTHPLACE (State or foreign country) ILLINOIS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) REPT.		12b. KIND OF BUSINESS OR, IND.STRY U.S. Govt.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Res dence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3557 LEISURE WORLD BLVD.		
14. FATHER'S NAME HERMAN		First	Middle	Last	15. MOTHER'S MAIDEN NAME KLIPEL	First	Middle	Last	BUCKLEY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No		16b. SOCIAL SECURITY NO. 579-42-1258		17. INFORMANT LEONARD D. BURNS, HUSBAND, SAME AS ITEM 13		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Diabetes left side myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Diabetes left side Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> D. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 11, 1968</i> , to <i>Oct 15, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 14, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Albert H. Rollman</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>10/16/68</i>						
22d. PHYSICIAN'S NAME (Type) <i>ALBERT H. ROLLMAN</i>		22e. ADDRESS <i>406 SPRUCE ST. SPRUCE</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial 10-18-1968		23b. DATE 10-18-1968		23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL CEM.		23d. LOCATION (City or Town) Baltimore, Maryland		(County)		(State)
24. FUNERAL DIRECTOR Joseph Gowler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS		25a. REC'D. BY REGISTRAR OCT 18 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR
ROBERTA		Bynum.		Oct 14 1968	10 ⁰⁰
3. SEX	4 RACE	S. DATE OF BIRTH	5. AGE (In years last birthday)	IF UNDER 1 YEAR	
FEMALE	Negro	1/27/97	71 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Virginia	U.S.A.	MONTGOMERY			Md
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
Bethesda		Suburban		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	
Maryland		Montgomery	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4408 Gault Pl. N.E	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME
George Myrick					Rosie Brown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT	
No		—		Dorn Bush 726-50 19th st Phila Pa	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY					
IMMEDIATE CAUSE (a) <u>Gram negative sepsis</u>					
DUE TO, OR AS A CONSEQUENCE OF <u>Junk</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>multiple septic</u>					
DUE TO, OR AS A CONSEQUENCE OF <u>liver</u>					
(c) <u>deabetes mellitus</u>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (p)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town County State
22o. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) los saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE	ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type)		22e. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City or Town) (County) (State)
10-19-68		Lincoln			Sorland Rd Md
24. FUNERAL DIRECTOR		ADDRESS	25a. REG'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
A. Washington & Sons 4925 Deane Ave NE			OCT 17 1968		Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14566

14574

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from page 2 and 3, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Last	2o. DATE OF DEATH Month Day Year	2b HOUR AM PM
Lawrence A. Caday				OCT. 31 1968	4:30
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS HOURS MIN
Male	White	May 30 1902	66 yrs		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Washington DC	U. S. A.		Montgomery		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda	Suburban Hospital		Employee		
3a. J.S.JAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13a. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Md.	Montgomery		4114 - Stanford St.		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	Address
Michael J. Caday				Julie	Castello
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT	Approximate Interval Between Onset and Death		
Yes, 1943	162-579-278238	Marian C. Johnson	Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis					
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year PM	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
			19		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from: 10/14/68, 19, to 10/31/68, 19, that (I) (X) last saw the deceased alive on 10/31/68, 19, and that in my opinion death occurred on the date and hour and from the causes stated above (I) (X) (d) (d) (d) view the body after death					
22b. SIGNATURE Timothy James Tehan, MD.					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	22c. DATE SIGNED		
TIMOTHY JAMES TEHAN, MD.		8218 Wisconsin Ave., Bethesda, Md.	10/31/68		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town)	(County)	(State)
Burial	11/4/68	Mount Olivet Cemetery	Washington		D.C.
24. FUNERAL DIRECTOR	ADDRESS	25a. RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY,	7557 Wisconsin Ave., Bethesda, Md.	NOV 6 1968	Charles Judge		

• BM

• D

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

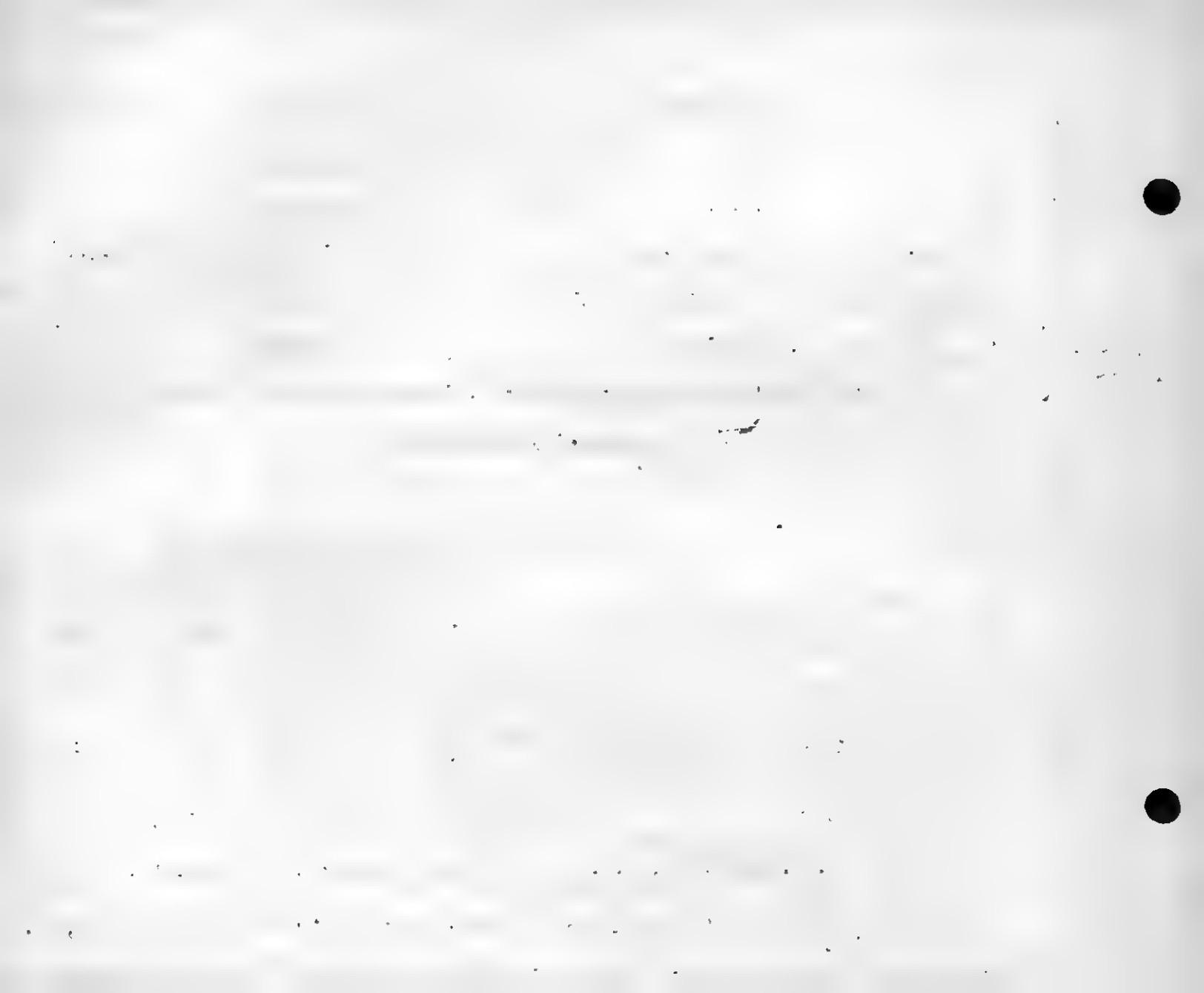
CERTIFICATE OF DEATH

14575

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First	Middle	Lost	20. DATE OF DEATH Month	Day	Year	2b. HOUR
		Herbert Leslie CAMPBELL			October	13	1968	3:25 AM
3. SEX		4 RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS M M N
Male		Cauc	8 April 1923			45 YRS.		
7a BIRTHPLACE (State or foreign (country))		7b. CIT.ZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH		
Colorado		U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda		Naval Hospital			Foreign Service Officer			State Dept
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Virginia		Fairfax	Greenway	YES <input type="checkbox"/> NO <input type="checkbox"/>		Madeira School		
14 FATHER'S NAME First		Middle	Last	15. MOTHER'S MAIDEN NAME First			Middle	Last
Elmer L. CAMPBELL				Stella KRAMER				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO			17 INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Yes		12-14-42-1-4-46 522220529			Mary K. CAMPBELL Greenway, Virginia			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).</p> <p>PART 1 DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Generalized lymphosarcoma</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>lost.</p> <p>(c)</p>								
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	yes		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
				19				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREETS, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
<p>22a. I certify that (s) (this hospital) attended the deceased from 4 Oct 1968, 1968, to 13 Oct 1968, 1968, that (s) (we) last saw the deceased alive on 13 Oct 1968, 1968, and that in (s) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (s) (not) view the body after death.</p>								
22b. SIGNATURE <i>J. E. Zimmerman, M.D.</i>		22c. DATE SIGNED Oct. 14, 1968						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
J. E. ZIMMERMAN, M.D.		Naval Hospital, Bethesda, Md.						
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 15 Oct 68	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Crematory			23d. LOCATION (City or Town) Suitland	(County) Prince Geo.	(State) Md.
24 FUNERAL DIRECTOR <i>D. Luckenbach</i>		ADDRESS Money and King Funeral Home, Vienna, Va.			25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
					DATE OCT 16 1968			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

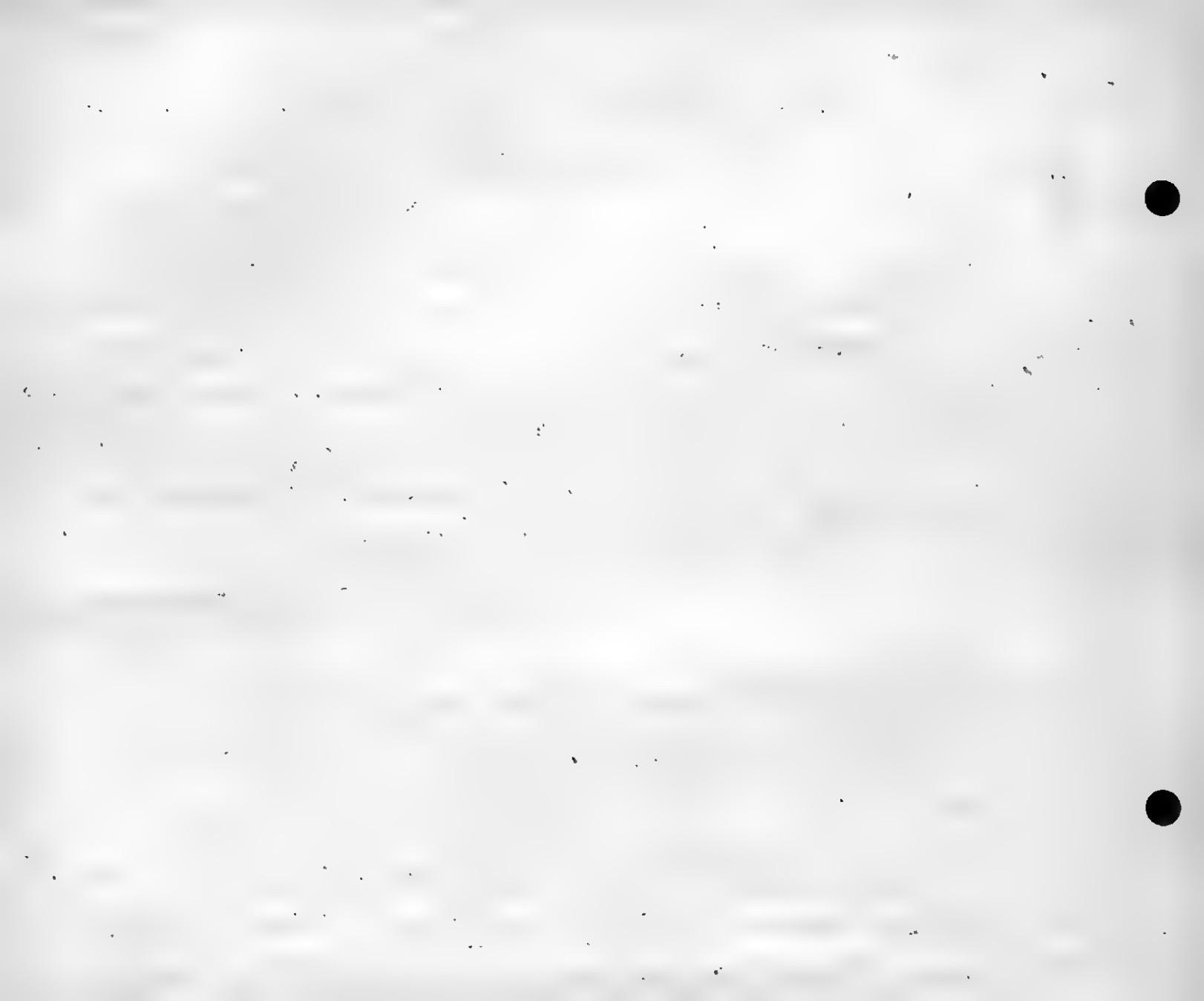
14576

14568

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Doy	Year	2b. HOUR
		AUBREY SYLVESTER		CARROLL	October	29	1968	5:35PM
3. SEX		4 RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE		WHITE	9-12-08		60 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
MD.		U.S.			MONTGOMERY County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park		WASH. SAN		E HOSPITAL		DISABLED		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13c. CITY OR TOWN <input type="checkbox"/> INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
MD		WASH. D.C.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6320 SUTLAND RD. 20023		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
		J. Geo. T. Carroll			ANN	S.	PAGGETT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
No		579-10-0418		Grace C. Armstrong-6320-Sutherland Rd SE				
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Pulmonary infarction</i> Approximate interval between onset and death <i>Minutes</i></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Stole</i> (b) <i>Pulmonary embolism</i> Minutes</p> <p>Due to, or as a consequence of <i>lost</i> (c) <i>Bronchogenic carcinoma</i> Months</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>Breathless mellites: Acute 2^o fulminant</p>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
10/28/68				YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
<p>22a. I certify that (I) (this hospital) attended the deceased from SEPT, 1968, to OCT 18-68, that (I) (we) last saw the deceased alive on 10/29/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.</p>								
22b. SIGNATURE		<i>Almaeth C. Cruze</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Oct. 30-68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 831 University Blvd E. Silver Spring MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 1-1968		23c. NAME OF CEMETERY OR CREMATORIAL Christ Church Cem.		23d. LOCATION (City or Town) Clinton		(County) MD (State)
24. FUNERAL DIRECTOR Simmons' Brothers-1446-Good Hope Rd SE		ADDRESS WASH DC		25a. REC'D BY REGISTRAR NOV 1 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

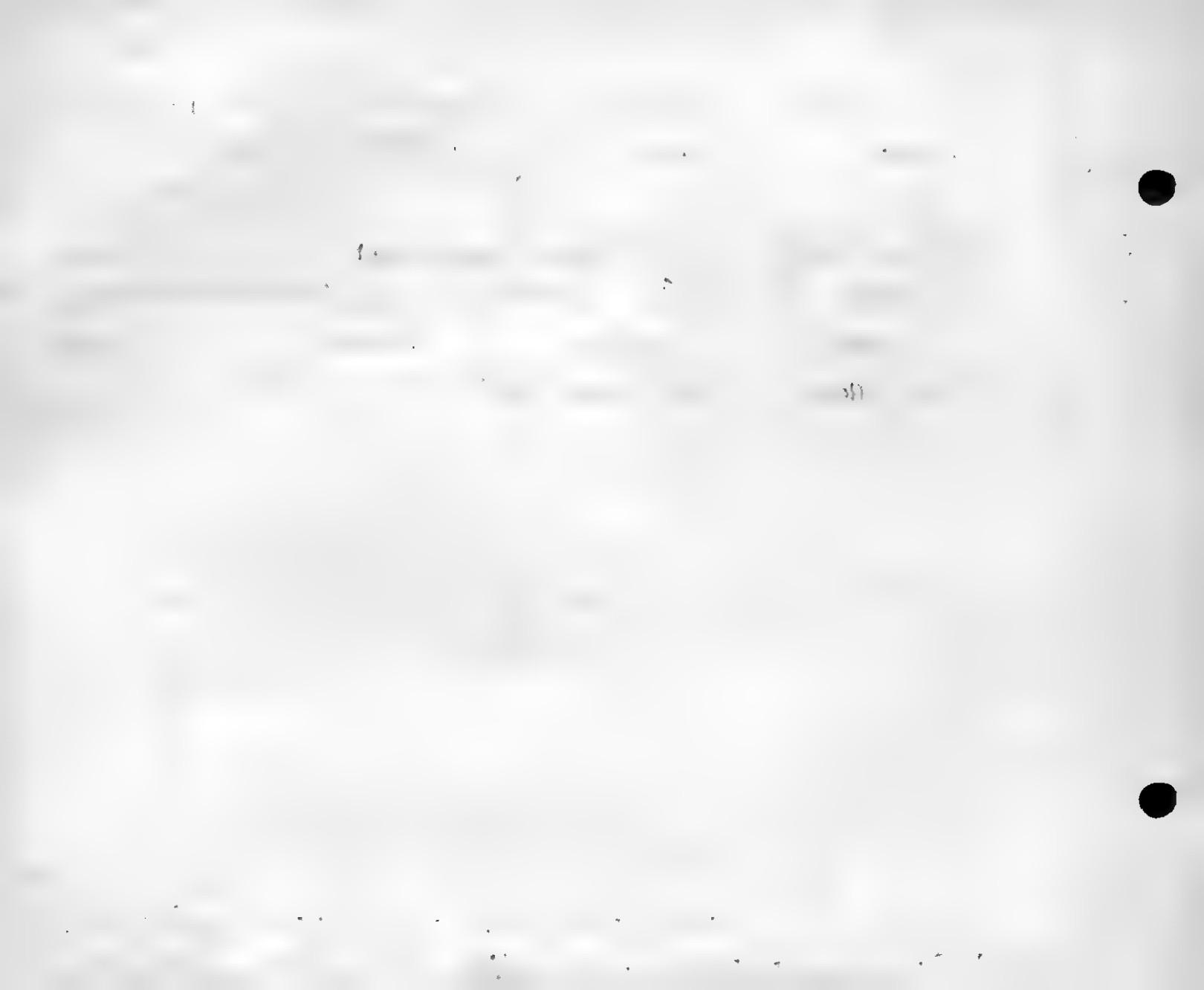
14569

CERTIFICATE OF DEATH

14577

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**PAGE 4** may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon paper pages 1 and 2 from this page. Then please remove carbon paper pages 1 and 2 from the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 from this page. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First Marion	Middle Holly	Last Carter	2a. DATE OF DEATH Month 10 Day 16 Year 68	2b. HOUR 4:20 AM
3 SEX Male	4. RACE white	5. DATE OF BIRTH 4-14-09	6. AGE (In years last birthday) 59 5/8 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) ALA.	7b. CITIZEN OF WHAT COUNTRY? Amer.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	12d. KIND OF BUSINESS OR INDUSTRY Laundry	
10 CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hospi.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk	
13c. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Md.	13e. CITY OR TOWN Lanham	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5606 Whitfield Chapel Rd		
14. FATHER'S NAME First Middle Last Frank Carter	15 MOTHER'S MAIDEN NAME First Middle Last Mabel Rogers				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown No None	16b. SOCIAL SECURITY NO. 253-05-0019	17 INFORMANT Patient's chart	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 to 10 minutes	
(b) Severe Coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)				15 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Lobular pneumonia of lower lobe of left lung					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year PM 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from June, 1967, to Oct 15, 1968, that (I) (we) last saw the deceased alive on Oct 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert B. Irey	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10/16/68	
22d. PHYSICIAN'S NAME (Type) ROBERT B. IREY	22e. ADDRESS 1161 New Hampshire Ave, Silver Spring, Md.				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 19, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ATHENS CITY Cemetery	23d. LOCATION (City or Town) Athens Limestone, Ala.	(County)	(State)
24. FUNERAL DIRECTOR F. Gasch's SONS	ADDRESS Hyattsville, Md.	25a. REC'D. BY REGISTRAR DATE OCT 21 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DIRECTOR.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with from Page 3 to TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

Items 18-22a Film 406 MARYLAND STATE DEPARTMENT OF HEALTH
11-19-68ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14578

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b HOUR		
		ALICE ERNE STINE COSSAR M.		Cassar	X	10-31		1968	11:56		
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD			2d. HOUR		
Female	White	1-28-96	72 YRS			Month	Day	Year	pr		
7a. BIRTHPLACE (State or foreign country) Mich.		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH	Montgomery			Md.		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park		Wash. San. & Hosp.		Housewife		own home					
13a. USUAL RESIDENCE (Where deceased lived, if institution Resdence before admission) STATE Md.		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
		Mont.		S.S.		YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	509 Deerfield Ave.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
		John Mattigan		Mattigan	Mary Duggan			Duggan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
None		579-48-3051M		Daughter		Mrs. Judith McCombs, 13811 Eastland St., Rockville					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation due to smoke										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
890X DUE TO, OR AS A CONSEQUENCE OF (b) inhalation and multiple burns, generalized DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7160											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 11:45 AM 10-31, 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) Deceased burned in housefire							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No.		City or Town		County	State		
						Silver Spring		Montg.	Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED	
Belden R. Reap, M.D.										Nov. 1, 1968	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIALy Gate of Heaven Cemetery				23d. LOCATION (City or Town) Silver Spring		(County) Mont.	(State) Md.
Burial		11/4/68									
24. FUNERAL DIRECTOR		M. Andrew Duwall		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
		Warren E. Pumphrey Inc.		8434 Ga. Ave. S.S., Md.				DATE NOV 7 1968		Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14579

1. DECEASED NAME (Type or print)	First LOUISE	Middle R.	Last CATTANEO	2a. DATE OF DEATH Month October Year 1968 Day 17 Hour 0700	2b. HOUR
3. SEX Female	4 RACE White	S. DATE OF BIRTH Date 5/1885	6. AGE IN YEARS at death WIDOWED	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MINS 0	IF UNDER 24 HRS MONTHS 0 DAYS 0 HOURS 0 MINS 0
7a. BIRTHPLACE (State or foreign country) Venice, Italy	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery County Md.	12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crescentor Nsg. Home	12a. USUAL OCCUPATION (Kind of work done during most working time even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) 1607 Lamar Road, Wash. D.C.	13c. CITY OR TOWN Wash. D.C.	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Bethesda, Maryland		
14. FATHER'S NAME First JOHN	Middle DE	Last CAL	15. MOTHER'S MAIDEN NAME First -	Middle -	Last -
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17. INFORMANT J77-01-8793-D - MR PETER CATTANEO, SON	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Brachio-pneumonia</i> 485 X DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491 X (c) DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 days		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>arteriosclerotic heart disease with chronic failure</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on 10-15-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <i>C P Ryland</i>	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 10-15-68	
22d. PHYSICIAN'S NAME (Type) C P RYLAND	22e. ADDRESS 4400-49th St. Washington, D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-18-1968	23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) Washington, D.C.		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016	ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 18 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 3
Items 18-22a Film 406 MARYLAND STATE DEPARTMENT OF HEALTH
11-14-68 am DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14580

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office to go with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Dept. Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item#2a & Film 406 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)	First Elias	Middle rnm	Last Chintolas	2a DATE KNOWN OF EST. DEATH MATED 10-21-1968	Month Oct	Day 21	Year 1968	2b H.O.R. M			
3. SEX M	4. RACE White	5. DATE OF BIRTH 1-15-1880	6. AGE (in years last birthday) 88 yrs	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month Oct	Day 21	Year 1968	2d HOUR 10:30
7a. BIRTHPLACE (State or foreign country) GREECE	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Montgomery								
10. CITY OR TOWN OF DEATH Takoma Park, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RESTAURANT WORK			12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input type="checkbox"/>		13e. STREET AND NUMBER 900 McCleary Ave., Silver Spring					
14. FATHER'S NAME GEORGE		Middle CHINTOLAS	Last HELEN UNKNOWN	15. MOTHER'S MAIDEN NAME DEMENIOS TSINTOLAS		16. SOCIAL SEC JURITY NO 563-16-4443		17. INFORMANT Geo Mc Ceney, Mrs. G. Mc Ceney			ADDRESS 1000 Rockville Rd., Silver Spring, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 9500		Acute barbiturate intoxication due to									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		DUE TO, OR AS A CONSEQUENCE OF overdose of Nembutal									
		DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9702											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. - P.M. 10-21 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased, depressed, took overdose of nembutal			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. Silver Spring			City or Town Silver Spring	County Montgomery	State Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Belden R. Keay</i>		CHIEF MEDICAL EXAMINER M.D.			ASSISTANT MEDICAL EXAMINER D.E.P. M.D.			22b. DATE SIGNED 10/21/68			
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER D.E.P. M.D.			ADDRESS (City or Town, County, State)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 23 Oct. 1968		23c. NAME OF CEMETERY OR CREMATORIUM GLENWOOD CEMETERY			23d. LOCATION (City or Town) Washington 6700		(County) Washington	(State) D.C.	
24. FUNERAL DIRECTOR PINASI FUNERAL HOME		ADDRESS 7400 Georgia Ave., NW, DC		25a. REG'D. BY REGISTRAR 20012 OCT 23 1968		25b. REGISTRAR'S SIGNATURE John J. Pinasi					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 14 & 15 of 15

14581

1573										MEDICAL EXAMINER'S CERTIFICATE OF DEATH				
1. DECEASED NAME (Type or Print)		First		Middle		Lost		2a. DATE KNOWN OF ESTI. DEATH MATED		Month	Day	Year	2b. HOUR	
		Inez		L. Clark				<input checked="" type="checkbox"/> <input type="checkbox"/>		10-19		1968	11:40 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years long birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS						
F	W	6-30-69		77		MONTHS	DAYS	HOURS	MIN.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		DIVORCED		9. COUNTY OF DEATH			2d. HOUR	
Demarest, Georgia		U.S.A.		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Montgomery			11:40 AM	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY								
Takoma Park		Washington San & Hospt		Retired Clerk-U.S. Coast Guard										
13a. U.S.C.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13c. CITY OR TOWN		13d. INSIDE CTY LIMITS?		13e. STREET AND NUMBER								
		Pr. Leo. ✓ North County		YES <input type="checkbox"/> NO <input type="checkbox"/>		7241 Garland Ave.								
14. FATHER'S NAME		First		Middle		Lost		15. MOTHER'S MAIDEN NAME		Fi		M date		
Felix Maryland		William		Walker House				Lula Hatwell		Bilata Dillard		Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
(If yes give war or dates of service)				Mrs. Lucille Gotthardt		7241 Garland Ave								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> (Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause lost.) <i>Arteriosclerotic Heart Disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4129 (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State				
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Belden R. Belden</i>		EXAMINER'S NAME (Type) <i>Belden R. Belden</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 10/19/68		
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE burial: 10/22/68		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National Cem., Ft. Myer, Va.		23d. LOCATION (City or Town) (County) (State)								
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
						MFT 23 1968		W. Belden, Jr.						



14571

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

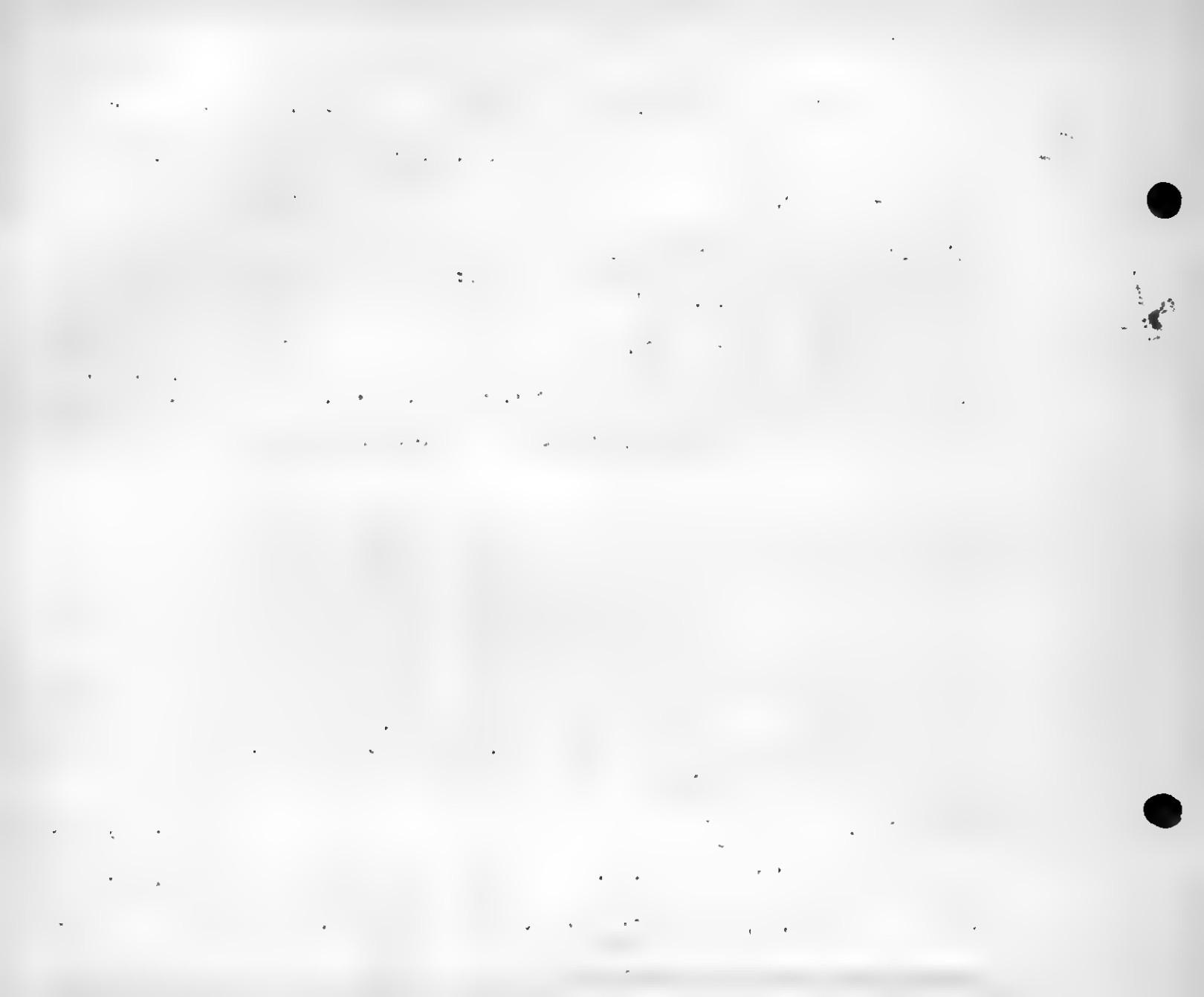
14582

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Julius	Middle Renaldo	Last CLARK	20. DATE OF DEATH Month Oct.	Day 15	Year 68	2b. HOUR 1040R
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH Apr. 10, 1967			6. AGE (In years last birthday) 18	IF UNDER MONTHS 18	YEAR DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13c. CITY OR TOWN Park	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 72 Coral Place				
14. FATHER'S NAME First Thomas	Middle Lee	Last Clark	15. MOTHER'S MAIDEN NAME First Mary	Middle Frances	Last Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) N/A	17. INFORMANT Mrs. Mary F. Clark, 72 Coral Pl. Lexington	Address Park, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 485X						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 441							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>(If either, notify medical examiner)</small>		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. 3:00 P.M.	City or Town 3:00 P.M.	County 3:00 P.M.	State 3:00 P.M.
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 15 / 1968 , to Oct. 15, 1968 , that (I) (we) last saw the deceased alive on Oct. 15 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE Bernard Jay Bortz		DEGREE Phys.	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED Oct. 16, 1968	
22d. PHYSICIAN'S NAME (Type) Bernard Jay Bortz, M. D.		22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 18, 1968	23c. NAME OF CEMETERY OR CREMATORIAL First Baptist Church Cemetery, Hermansville		23d. LOCATION (City or Town) Hermansville	(County) Md.	(State)
24. FUNERAL DIRECTOR Mattingly Funeral Home		AD Home		25a. REC'D BY REGISTRAR DATE OCT 21 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		
Leonardtown, Maryland		<i>W. Clarke Mattingly</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

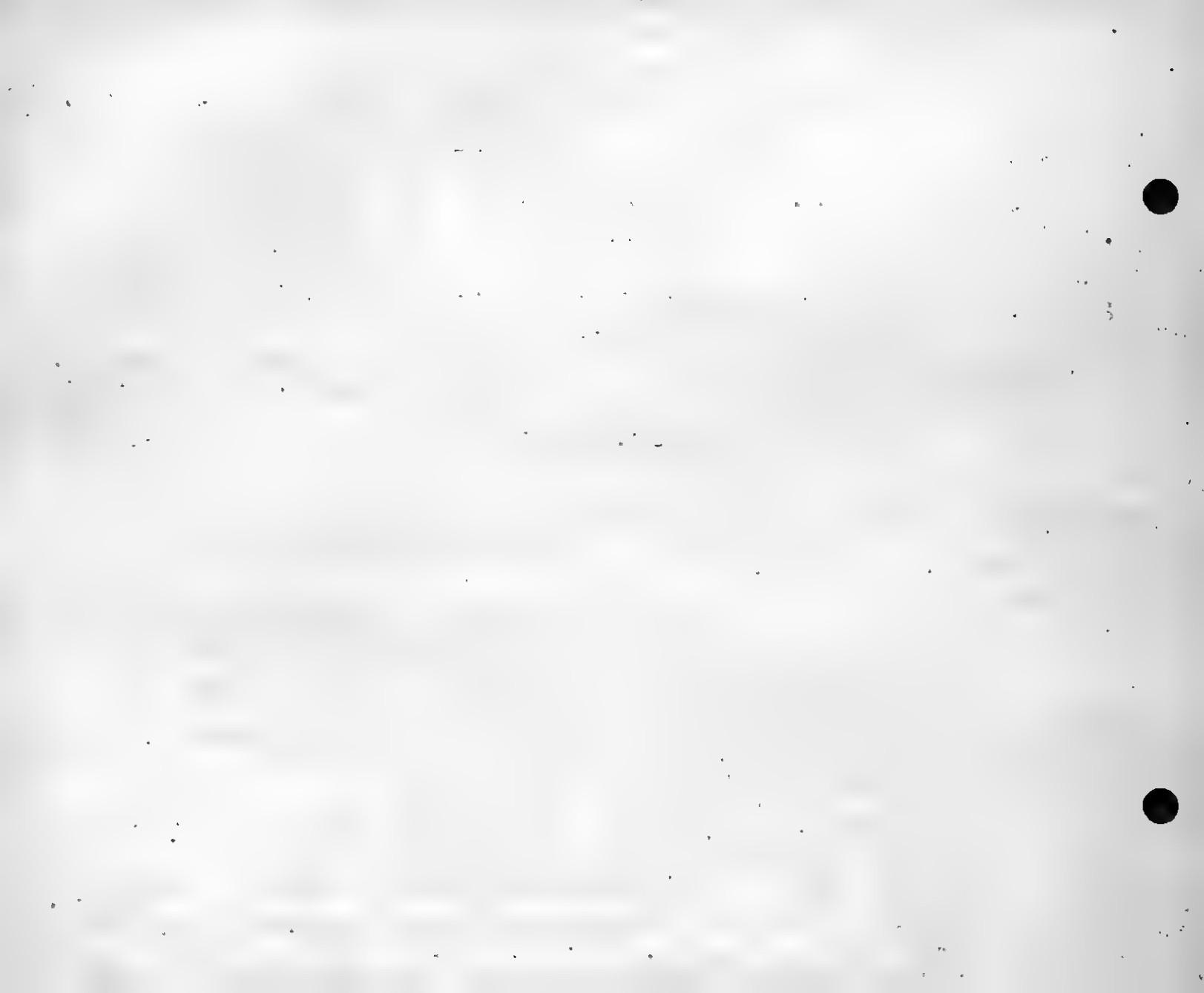
14583

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First MARGARET	Middle CLASPY	Last	20. DATE OF DEATH Month 10 - 20 - 68	2b HOUR 12 P.M.
3. SEX Female		4. RACE Caucasian		S. DATE OF BIRTH 3-1-1880	6. AGE (In years lost birthday) 88 YRS.	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give full address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, except retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		lived, if institution: Residence before 13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1702 Alberti Drive
14. FATHER'S NAME John		Middle Riddle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown		16b. SOCIAL SECURITY NO. -		17. INFORMANT William G. Claspy Jr., Son, 1702 Alberti Dr.	Silver Address Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CEREBRAL HEMORRHAGE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 Minutes		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b)				
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIOSCLEROTIC HEART DISEASE WITH HYPERTENSION						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <u>8-6-1968</u> to <u>10-7-1968</u> , that (I) (we) last saw the deceased alive on <u>10-7-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>C.P. Rypley</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10-20-68	
22d. PHYSICIAN'S NAME (Type) <i>C.P. Rypley</i>		22e. ADDRESS 4400-49 St. N.W.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-23-1968	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION (City or Town) Cooper, Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS 5130 Wisc. Ave.	25a. REC'D BY REGISTRAR DATE OCT 23 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14584

1. DECEASED NAME (Type or print)	First <i>Betty</i>	Middle <i>Cole</i>	Last	2a. DATE OF DEATH Month Oct.	Day 27	Year 68	2b. HOUR 4 PM		
3. SEX <i>F</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>8/29/24</i>	6. AGE (In years last birthday) <i>44 yrs</i>	7. IF UNDER MONTHS	8. IF UNDER YEARS DAYS	9. IF UNDER 24 HRS. HOURS	10. IF UNDER MIN.		
7a. BIRTHPLACE (State or foreign country) <i>England</i>	7b. CITIZEN OF WHAT COUNTRY? <i>British</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>						
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Nursing</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Montgomery</i>						
13a. USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Kensington</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>3901 Byrd Lane</i>					
14. FATHER'S NAME First <i>L.</i>	Middle <i>Sugden</i>	Last	15. MOTHER'S MAIDEN NAME First Middle <i>Winifred</i>	Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>***</i>	17. INFORMANT <i>Mr. James Cole</i>	Address <i>Same as above</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inflammation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Obstruction</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i>				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinomatosis</i>					4 mos				
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of ovary</i>					18 mos				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION <i>June '68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal Obstruction</i>	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING (If either, notify medical examiner) <input type="checkbox"/> <input type="checkbox"/>	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While at work <input type="checkbox"/> <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 19 <i>68</i> , to <i>date</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10-27-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (do not) view the body after death.									
22b. SIGNATURE <i>R. A. F. Castro MD</i>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>10-27-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>R. A. F. Castro</i>	22e. ADDRESS <i>11125 Rockville Pk. Rockville</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>	23b. DATE <i>10/29/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>	23d. LOCATION (City or Town) <i>Suitland, Pr. Geo. Md.</i>	(County) <i>Pr. Geo. Md.</i>		(State) <i>Md.</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PLUMPHREY</i>	ADDRESS <i>7557 Wisconsin Ave., Bethesda, Maryland</i>	25a. REC'D. BY REGISTRAR <i>NOV 4 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14585

1457

Liberata

1 DECEASED NAME (Type or print)	First LIBERATA	Middle	Last COLELLA	2a. DATE OF DEATH Month October Day 27 Year 1968	2b. HOUR 3:25 P.M.
2 SEX	4 RACE Female	S. DATE OF BIRTH Feb 16-1885	6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) ITALY	7b. CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RANDOLPH HILLS N.H.	12a. US-JAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S-JAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13c. CITY OR TOWN MONTGOMERY	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9303 WISCONSIN AVENUE		
14. FATHER'S NAME First DOMENICO	Middle	Last PATRIZIO	15. MOTHER'S MAIDEN NAME First	Middle	Last
16a. WAS DECEASED EVER IN U.S ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. —	17. INFORMANT MR. DOMINIC COLELLA, SON, SAME AS ITEM #13	Address		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 403 X Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week		
(b) Myocardial insufficiency DUE TO, OR AS A CONSEQUENCE OF Cerebral thrombotic strokes			2 years		
(c) Hypertension, cerebral arteriosclerosis & cardiac sclerosis			20 years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443 X Old age.					
19a. DATE OF OPERATION 9/1/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION - Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 1968 to Oct 27, 1968, that (I) (we) last saw the deceased alive on Oct 27, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. N. Manganaro, M.D.	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10/27/68	
22d. PHYSICIAN'S NAME (Type) R. N. Manganaro, M.D.	22e. ADDRESS 1410-MASS. AVE. N.W.				

23a. BURIAL, CREMATION BURIAL	23b. DATE 10-31-1968	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery	23d. LOCATION (City or Town) Silver Spring, Mont. Co., Md.	(County) (State)
24. FUNERAL DIRECTOR Joseph Hawlerissons	ADDRESS 5130 Wisconsin Avenue	25a. REG'D BY REG STRAR DATE OCT 30 1968	25b. REG STRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

* 4578						14586						
1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- MATED			Month	Day	Year	2b. HOUR
Ralph			Adolph	Colwell		<input checked="" type="checkbox"/>			Oct.	27	1968	8:30 A
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR	8 IF UNDER 24 HRS	MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD		
Male	White	Nov. 19 1915	52 YRS							Month	Day	Year
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		<input checked="" type="checkbox"/> NEVER MARRIED		<input type="checkbox"/>		9. COUNTY OF DEATH		
Minnesota		U. S. A.		<input checked="" type="checkbox"/> MARRIED		<input type="checkbox"/> DIVORCED		Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. JSJAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Kensington			3522 Nimitz Rd., Kensington, Maryland			Md.			U.S. Govt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
Maryland			Montgomery			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			Kensington, Md.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Harry			L.	Colwell		Esther						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
yes			1171-15-8351			Mrs. Loretta A. Colwell, 3522 Nimitz Rd.			Kensington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY.												
IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u>												
DUE TO, OR AS A CONSEQUENCE OF <u>artery</u>												
(b) <u>Coronary heart/disease</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
MEDICAL CERTIFICATION			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
			21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No Cty or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Bolder R. Recp</i>			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>Wheaton, Maryland</i>			22b. DATE SIGNED <i>October 27, 1968</i>			
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE <i>10-30-1968</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Lincoln Cemetery</i>			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>J.W. Lee</i>			ADDRESS <i>11 Spr. Md.</i>			25a. REC'D BY REGISTRAR <i>OCT 31 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15ME (5) 10M REV 1/68												



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14579

14587

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, remove carbon paper, fold and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First JOHN	Middle FRANCIS	Last CONLON	2a. DATE OF DEATH Month Oct	Year 1968	2b. HOUR 10 A.M.	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH 5-4-1911			6. AGE (in years last birthday) 57	.F. UNDER 1 YEAR MONTHS DAYS	F. UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) California	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's County			Montgomery Md
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Administrative ass't			12b. KIND OF BUSINESS OR INDUSTRY U.S. Senate
13a. US.JAL RESIDENCE (Where deceased lived, if institution Reside before admission) STATE Maryland	13c. CITY OR TOWN Prince Georges Chillum	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 6604 Karlson Court		
14. FATHER'S NAME Patrick Francis Conlon	15. MOTHER'S MAIDEN NAME Mary Burke						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes	16b. SOCIAL SECURITY NO 503-07-4936	17. INFORMANT Mrs. Alberta N. Conlon, Wife, same as #13	Address				
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> 5 years (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1962 to Oct 1968, that (I) (we) last saw the deceased alive on 9/11 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>J. E. Fitzgerald</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Oct 10 1968		
22d. PHYSICIAN'S NAME (Type) J. E. Fitzgerald	22e. ADDRESS 3750 Reservoir Rd NW						
23a. BURIAL, CREMATION, REMOVAL (Specify) Renovate-Burial	23b. DATE 10-9-1968	23c. NAME OF CEMETERY OR CREMATORIAL Palm Cemetery	23d. LOCATION (City or Town) Las Vegas, Nevada			(County)	(State)
24. FUNERAL DIRECTOR Creeph Funeral's Sons, Inc. 5130 Wisc. Ave. N.W., Wash., D.C., 20016	ADDRESS			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE OCT 10 1968 <u>Charles Judge</u>		

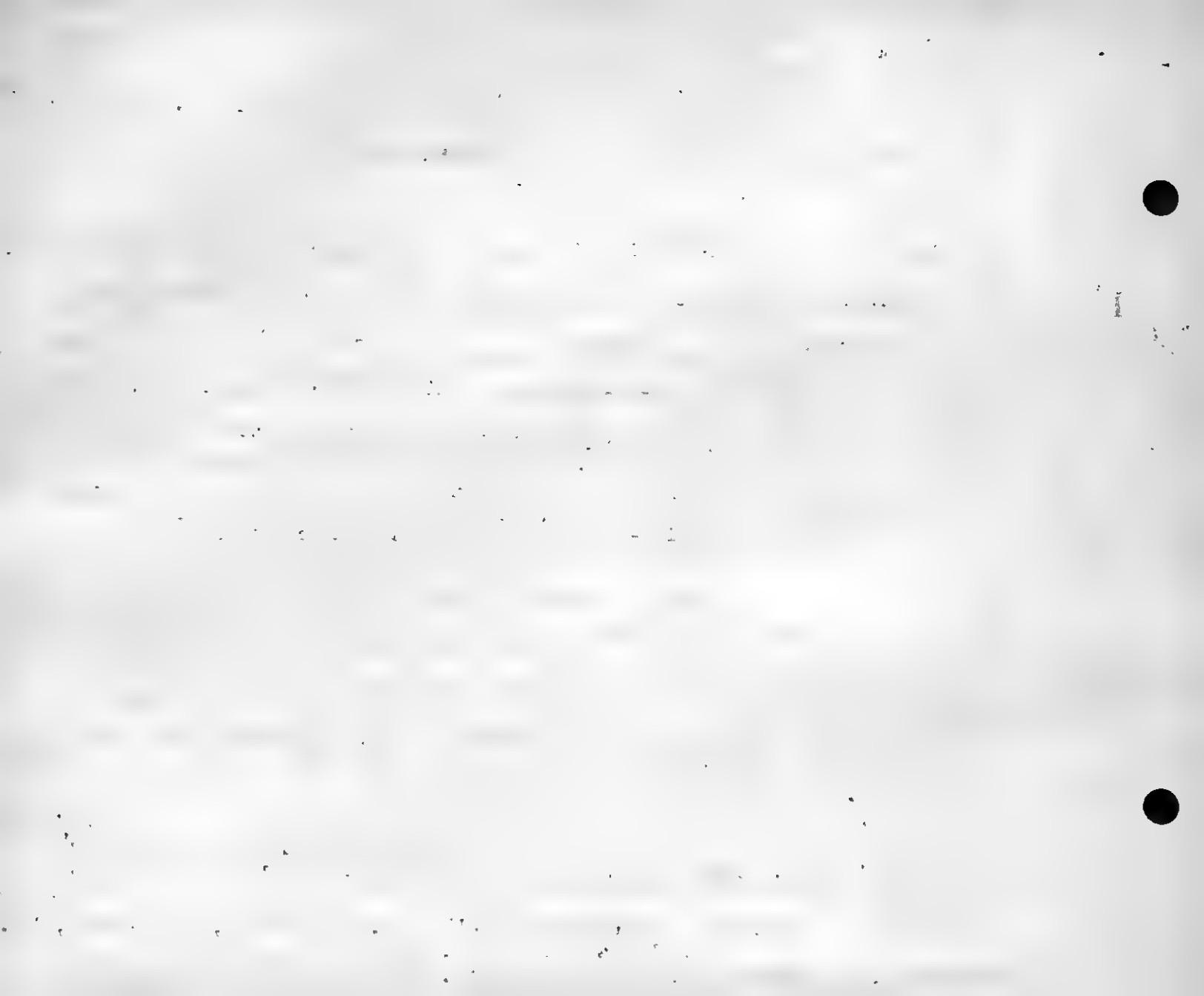


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

18
14580
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Ann	Middle (NMN) Corbley	Lost	2a. DATE OF DEATH Month October Year 1968	2b. HOUR AM 4:45 M
3. SEX Female	4. RACE White	S. DATE OF BIRTH February 14, 1905	5. AGE (in years last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Georgia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	Md.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Saleslady: Retired	12b. KIND OF BUSINESS OR INDUSTRY Retail Mdse		
13a. U.S. JAIL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6704 Hillandale Road	
14. FATHER'S NAME Charles	First Middle Blume	15. MOTHER'S MAIDEN NAME Pearl	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO XXX-07-0011	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute and chronic respiratory failure secondary to chronic bronchitis and emphysema 40 days DUE TO, OR AS A CONSEQUENCE OF Generalized peritonitis secondary (b) to ileal loop perforation 2 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause DUE TO, OR AS A CONSEQUENCE OF Advanced recurrent carcinoma of the cervix - post-operative total pelvic exenteration 7 months (c) cervix - post-operative total pelvic exenteration 7 months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION 8/26/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of cervix	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 11, 1968, to October 9, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 9, 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (do not) view the body after death.					
22b. SIGNATURE Peter J. Deckers, M.D.	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/9/68	
22d. PHYSICIAN'S NAME (Type) Peter J. Deckers, M.D.	22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/14/68	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Nat'l	23d. LOCATION (City or Town) Cem. Baltimore, Baltimore, Md.	(County)	(State)
24. FUNERAL DIRECTOR ROBERT A. PIUMPHREY, Bethesda, Maryland	ADDRESS 7557 Wisconsin Ave.	25a. REC'D BY REGISTRAR DAT OCT 14 1968	25b. REGISTRAR'S SIGNATURE j Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14581

14589

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Pearl	Middle Jean	Last COX	2a DATE OF DEATH Month 10 Day 21 Year 1968	2b HOUR 1:45 A.M.		
3 SEX Female	4 RACE Cauc	5 DATE OF BIRTH 3 Feb 1926		6 AGE (in years last birthday) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Michigan	7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Purchasing Agent	12b KIND OF BUSINESS OR INDUSTRY Navy Exchange		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b COUNTY	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 4919 Frederick Ave.			
14 FATHER'S NAME Arthur Tourtellote	First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. (If you give war or dates of service) 214 20 6062	17 INFORMANT John H. COX	4919 Frederick Ave. Baltimore, Md.		Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the breast with widespread metastases</u>							
174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost,							DUE TO, OR AS A CONSEQUENCE OF
(b)							DUE TO, OR AS A CONSEQUENCE OF
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
170X							
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 26 September 68, to 21 October 1968, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 21 October 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE <u>J.W. Fouty</u>	DEGREE ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/>	22c. DATE SIGNED 22 Oct. 1968
22d. PHYSICIAN'S NAME (Type) W. J. FOUTY, M. D.	22e. ADDRESS Naval Hospital, Bethesda, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 24, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery	23d. LOCATION (City or Town) Baltimore, Md.		(County)	(State)	
24. FUNERAL DIRECTOR Truman Schwab Funeral Home, Baltimore, Md.	ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 25 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14582

14580

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)	First Larry	Middle Johnson	Last Creeger Jr	2a. DATE OF DEATH Month 10 Day 17 Year 68 10-17-68	2b. HOUR M
3. SEX male	4. RACE white	5. DATE OF BIRTH 10-17-68	6. AGE (in years last birthday) YRS. 5	IF UNDER 18 YEARS MONTHS 0 DAYS 0 HOURS 0 MIN 6	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Co., Md.		
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE m d	13b. COUNTY Montgomery	13c. CITY OR TOWN Germantown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME First Larry	Middle Johnson	Last Creeger	15. MOTHER'S MAIDEN NAME First Linda	Middle Sue	Last Golden
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Birth Certificate	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary atelectasis 1164 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Immaturity DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 1625					
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either not by medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9:00 A.M. 1968, to 11:00 A.M. 10/17/68, that (I) (we) last saw the deceased alive on 10/17/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph G. Dugan, M.D.	DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED 10/17/68
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 50 W. Edmonston Dr. - Rockville				
23a. BURIAL/CREMATION, REMOVAL (Specify)	23b. DATE 10/17/68	23c. NAME OF CEMETERY OR CREMATORIAL Suburban Hospital	23d. LOCATION (City or Town) Bethesda - Montg. - MD	(County)	(State)
24. FUNERAL DIRECTOR MRS. Amelia S. Carter Administrator	ADDRESS " "	25a. REC'D. BY REGISTRAR ACT 23 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

1000
100
10

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14583

CERTIFICATE OF DEATH

14591

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR AM/PM		
<i>Joseph T. Cimella</i>						October 31 1968	12:00 PM		
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (in years from last birthday)				
MALE		White	Jan 3, 1896		72 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH				
Italy		U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery Md.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a US.J.L OCCUPATION (Kind of work done during most of working life, even if retired)		12b TRADE OR INDUSTRY		
Bethesda		SUBURBAN Hosp.			Montgomery Chevy Chase		4607 Elm St.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Md.		Montgomery		Chevy Chase					
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last	
Panzica				Cimella	Cleopatra	I	Rosaria		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
Yes		578-01-7765		Son Joseph. Same as above					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>527</u> (b) <u>Pulmonary edema and pleural effusion</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Emphysema and pleural fibrosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory or office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 30 1968</u> to <u>Oct. 31 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct. 30 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>J.C. Brown</i>		DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10-31-68</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>VICENTE J. De GUZMAN MD</i>							
23a. BURIAL, CREMATION, REMOVAL Specified		23b. DATE Nov. 4, 68		23c. NAME OF CEMETERY OR CREMATORIAL Mt Olivet Cemetery		23d. LOCATION (City or Town) Washington, D. C.		(County) (State)	
24. FUNERAL DIRECTOR Robert A Pumphrey		ADDRESS 7557 Wisconsin Ave Bethesda, Md.		25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14592

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: Richard	Middle: Cromwell	Last: Lost	2a. DATE OF DEATH Month: 10 Day: 31 Year: 1968	2b. HOUR 10 AM
3. SEX <i>m</i>	4. RACE <i>Caucasian</i>	S. DATE OF BIRTH <i>4/26/1885</i>	6. AGE (in years last birthday) <i>88 yrs.</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MM	
7a. BIRTHPLACE (State or foreign country) <i>Bethesda, Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Maryland</i>	Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bethesda Nursing Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Clerk</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res.dence before admission) STATE <i>De. / MD</i>	13c. CITY OR TOWN <i>Wash.</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>46607 Conn. Ave. NW</i>		
14. FATHER'S NAME First: Arthur	Middle: Cromwell	15. MOTHER'S MAIDEN NAME First: Christie	Middle: Trundle	Last:	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown <i>No</i>	16b. SOCIA. SECURITY NO <i>215-67-3691</i>	17. INFORMANT <i>J. Arthur Cromwell</i>	Address <i>Same as above</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>canceroma of bladder</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arterio Sclerotic Cardiovascular disease</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>10/31/1968</i> , to <i>10/31/1968</i> , that (I) (we) last saw the deceased alive on <i>10/31/1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (do not) view the body after death					
22b. SIGNATURE <i>R. J. Cromwell</i>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>10/31/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>W. B. Helle</i>	22e. ADDRESS <i>Barnstable</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>11/2/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Monocacy</i>	23d. LOCATION (City or Town) <i>Beallsville Montg. Md.</i>	(County) <i>Montgomery</i>	(State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>William B. Helle, Barnstable</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>NOV 6 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)		First (Theresa)	Middle Teresa	Lost Marie			2a. DATE KNOWN OF DEATH ESTIMATED	Month 10	Day 19	Year 1968	2b. HOUR 4:40 A.M.
3. SEX female	4. RACE white	S. DATE OF BIRTH 1-4-95	6. AGE (in years at birthday) 73 yrs	IF UNDER MONTHS 73	YEAR 0	IF UNDER 24 HRS HOURS 0	MIN 0	2c. DATE PRONOUNCED DEAD Month October			2d. HOUR Year 1968
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium				12a. USWAL OCCUPATION (Kind of work done during most of working life even if retired) Housewife				12b. KIND OF BUSINESS OR INDUSTRY at home	
13a. USLAI RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Maryland		13c. C.TY OR TOWN Prince George		13d. INSIDE C.TY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3325 Lancer Drive					
14. FATHER'S NAME First (Luigi)		Middle Rubino	Lost	15. MOTHER'S MAIDEN NAME First Carmela		Middle Tantaleena	Lost				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Patient's chart				ADDRESS			
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>acute tracheo-bronchitis with secondary pulmonary atelectasis</i> DUE TO, OR AS A CONSEQUENCE OF Conditons, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <i>acute tracheo-bronchitis with secondary pulmonary atelectasis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>secondary pulmonary atelectasis</i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1. Respiratory tract 2. Urinary tract infection</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b.)							
22d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Belden R. Pepp</i>		M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Belden R. Pepp M.D.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10.22.68		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION (City or Town) Colmar Manor Md		(County)		(State)	
24. FUNERAL DIRECTOR Lee Funeral Home. 300.4th st N E D.C.		ADDRESS Wash D.C.		25a. REC'D BY REGISTRAR DATE OCT 23 1968		25b. REGISTRAR'S SIGNATURE <i>Signature</i>					

1
2
3
4
5
6
7
8
9

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14586

14594

1 Within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician
 Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Then file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours of your death.

1. DECEASED NAME (Type or print)	First Joseph	Middle Samuel	Last Dagenhart	2a. DATE OF DEATH Month 10 Day 22 Year 68	2b. HOUR A.M. 4:50M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9-11-07		6. AGE (In years last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hos.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired). Orthopedic Tech.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13c. CITY OR TOWN Montgomery Sil. Spr.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 11235 Oakleaf Drive	12b. KIND OF BUSINESS OR INDUSTRY Gov't.		
14. FATHER'S NAME Charles	First EdwARD	Middle Dagenhart	Last Bertha	Middle May	Last Myers	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. 578-32-4584	17. INFORMANT Mildred B. Dagenhart	Address 11235 Oakleaf Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF, (b) <i>ASCVD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 42-1 DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hypercholesterolemia</i>						
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 22, 1968</i> , to <i>Oct. 22, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct. 15, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Fredrick Moorman M.D.</i>		ATTENDING DEGREE PHYS.	22c. MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	DATE SIGNED <i>Oct. 22, 1968</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>Medical Center, Sandy Spring, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Oct. 26, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>	23d. LOCATION (City or Town) <i>Coldwater</i>	(County)	(State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Arthur Lathers Washington, DC 20012</i>		ADDRESS <i>2021 Gardner St. N.W.</i>	25a. REGD. BY REGISTRAR <i>Charles Judge</i>	25b. DATE <i>OCT 28 1968</i>	REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14587

14595

10 HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

Cleared with Medical Examiner

1. DECEASED-NAME (Type or print)	First WILLIAM	Middle HENRY	Last DALKIN, SR.	2a. DATE OF DEATH Month 10 Day 13 Year 68	2b. HOUR 2:00 P.M.	
3. SEX male	4. RACE caucasian	5. DATE OF BIRTH 7/29/89		6. AGE (In years last birthday) 77	If UNDER 1 YEAR MONTHS YRS.	If UNDER 24 HRS. DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Washington, DC.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during working life, even if retired.) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Govt.
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland	lived, if institution Residence before 13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Sp.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9110 Providence Avenue		
14. FATHER'S NAME Robert	First Middle Dalkin	15. MOTHER'S MAIDEN NAME Margaret	Last Morton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO (If yes give war or dates of service) YES	17. INFORMANT Aileen G. Dalkin Address 9110 Providence Ave. S.S., Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 - 5 DODEN DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		4/17/68 CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis Several years				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4/17/68 Diabetes Mellitus						
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from July 5, 1955, to Oct. 13, 1968, that (I) (we) last saw the deceased alive on Sept. 19, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Lawrence D. Summerfield M.D.	22c. DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10-14-68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 3230 Pa. Ave. S.E. Washington D.C. 20020					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10-17-1968	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City or Town) Suitland	(County) Md.	(State) Md.	
24. FUNERAL DIRECTOR Gloria Carter Warren E. Pumphrey, Inc. 8434 Ga. Ave. S.S., Md.	ADDRESS	25a. REC'D BY REGISTRAR OCT 21 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14588 14556

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First GEORGE	Middle DANN	Last DANN	20. DATE OF DEATH 10 Month 18 Day Year 1968	2b HOUR 9:30 AM		
3. SEX Male		4. RACE White	5. DATE OF BIRTH 1/15/1900			6. AGE (in years lost birthday) 68 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Silver Spring, Md.		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant			12b. KIND OF BUSINESS OR INDUSTRY Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Silver Spring	13d. INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2305 Westview			
14. FATHER'S NAME Abraham		Middle Dann	15. MOTHER'S MAIDEN NAME First Chaya			Middle Weiss			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 578-46-8781		17. INFORMANT Harry Wolfe, Son-in-law			Address 2305 Westview Dr. S. S.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5510		DUE TO, OR AS A CONSEQUENCE OF (i) Hypertension						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr - 12 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 5490		DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes - Mr.						1 - 6 -	
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertension & Diabetes Mellitus, heart disease									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Oct. 14 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. William J. Danzansky		22c. DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	DATE SIGNED 10-13-68
22d. PHYSICIAN'S NAME (Type) BRAHIM W. DANZANSKY		22e. ADDRESS 1110 18th St. NW Washington, D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/20/68		23c. NAME OF CEMETERY OR CREMATORIAL Ohev Shalom Talmud Torah Cemetery			23d. LOCATION (City or Town) Capital Heights, Md.		(County) (State)
24. FUNERAL DIRECTOR Bernard Danzansky and Sons		ADDRESS 3501 14th St., N.W. Wash., D.C.			25a. RECD. BY REGISTRAR DATE OCT 13 1968			25b. REGISTRAR'S SIGNATURE James J. Danzansky	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14589

14597

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be detached for use as the burial-transit permit. Then please remove carbon paper. pages 1 and 2
 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. pages 1 and 2
 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Lost	20. DATE OF DEATH Month	2b HOUR
Emma	Beaulieu	Darling		Oct. 23	12:25 P.M.
21. SEX	4 RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	White	8-4-1880	88 YRS.		
7d. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH	Md.	
Vermont	U. S. A.		Montgomery		
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park	Washington San & Hospital	Housewife	home		
13a. USUAL RESIDENCE (Where deceased admission)	lived, if institution: Residence before 13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Maryland	Montgomery	Silver Spring		7705 Eastern Ave.	
14. FATHER'S NAME	First	Middle	15. MOTHER'S MAIDEN NAME	First	Middle
Ludger	Logga	Beaulieu	Unknown		Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address		
no	213-38-3443	John Fitzgerald	1221 Woodside Pkwy. Sil. Spr. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarct 1wk DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
4 x 01		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City of Town	County State
22a. I certify that (I) (this hospital) attended the deceased from July, 1965, to 10-23-1968, that (I) (we) last saw the deceased alive on 10-21-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death					
22b. SIGNATURE J. B. Langstack, M.D.		DEGREE	ATTENDING PHYS	MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 10-23-68
22d. PHYSICIAN'S NAME (Type) J. B. Langstack, M.D.		22e. ADDRESS 9341 Columbia Blvd. S. S. Md.			
23a. BURIAL CREMATION, REMOVAL <input type="checkbox"/>		23b. DATE Oct. 28, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National	23d. LOCATION (City or Town) Arlington	(County) (State) Virginia
24. FUNERAL DIRECTOR M. Andrew Duvall Warner E. Pumphrey, Inc., 8434 Ga., Ave., Md.		ADDRESS 8434 Ga., Ave., Md.	25a. REC'D BY REGISTRAR DATE OCT 30 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, 3, 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with a stamp. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14558

1 DECEASED NAME (Type or Print)			First CHARLES	Middle L.	Last DASHER, JR.	2a DATE KNOWN OF EST. DEATH MATED	Month 10	Day 31	Year 1968	2b HOUR PM
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH JULY 11, 1900	6. AGE (in years last birthday) 68 YRS	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	2c DATE PRONOUNCED DEAD Month 10	Day 31	Year 1968	2d HOUR 4:45 PM		
7a BIRTHPLACE (State or foreign country) GEORGIA		7b CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY				
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7812 Old Chester Road			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) RET.-MAG. GEN.			12b KIND OF BUSINESS OR INDUSTRY U.S. Army		
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE MARYLAND		13c CTY OR TOWN MONTGOMERY		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7812 OLD CHESTER ROAD				
14 FATHER'S NAME CHARLES		Middle L.	Last DASHER, SR.	15 MOTHER'S MAIDEN NAME ELOISE		16 ADDRESS - WILDER				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No, or unknown) YES		16b SOCIAL SECURITY NO WWII-KOREA		17 INFORMANT HELEN R. DASHER - SAME AS #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> . DUE TO, OR AS A CONSEQUENCE OF <u>4124</u> Conditions, if any, wh ch gave rise to immediate cause (a), stating the underlying cause (b) <u>coroio Vascular Disease</u> . DUE TO, OR AS A CONSEQUENCE OF lost (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 17										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State	
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JOHN G. BALL		John G. Ball -		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) MONTG. CO., MD.		22b. DATE SIGNED Oct 31, 1968				
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 11/4/68		23c NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT. Cem.		23d LOCATION (City or Town) (County) (State) ARLINGTON, VA.				
24 FUNERAL DIRECTOR Jos. GAWLEN'S SONS, 5130 WIS. AVE, WASH, D.C.		ADDRESS		25a REC'D BY REGISTRAR DATE NOV 7 1968		25b REGISTRAR'S SIGNATURE Charles Judge				



Item 6 Film GL406 14591 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

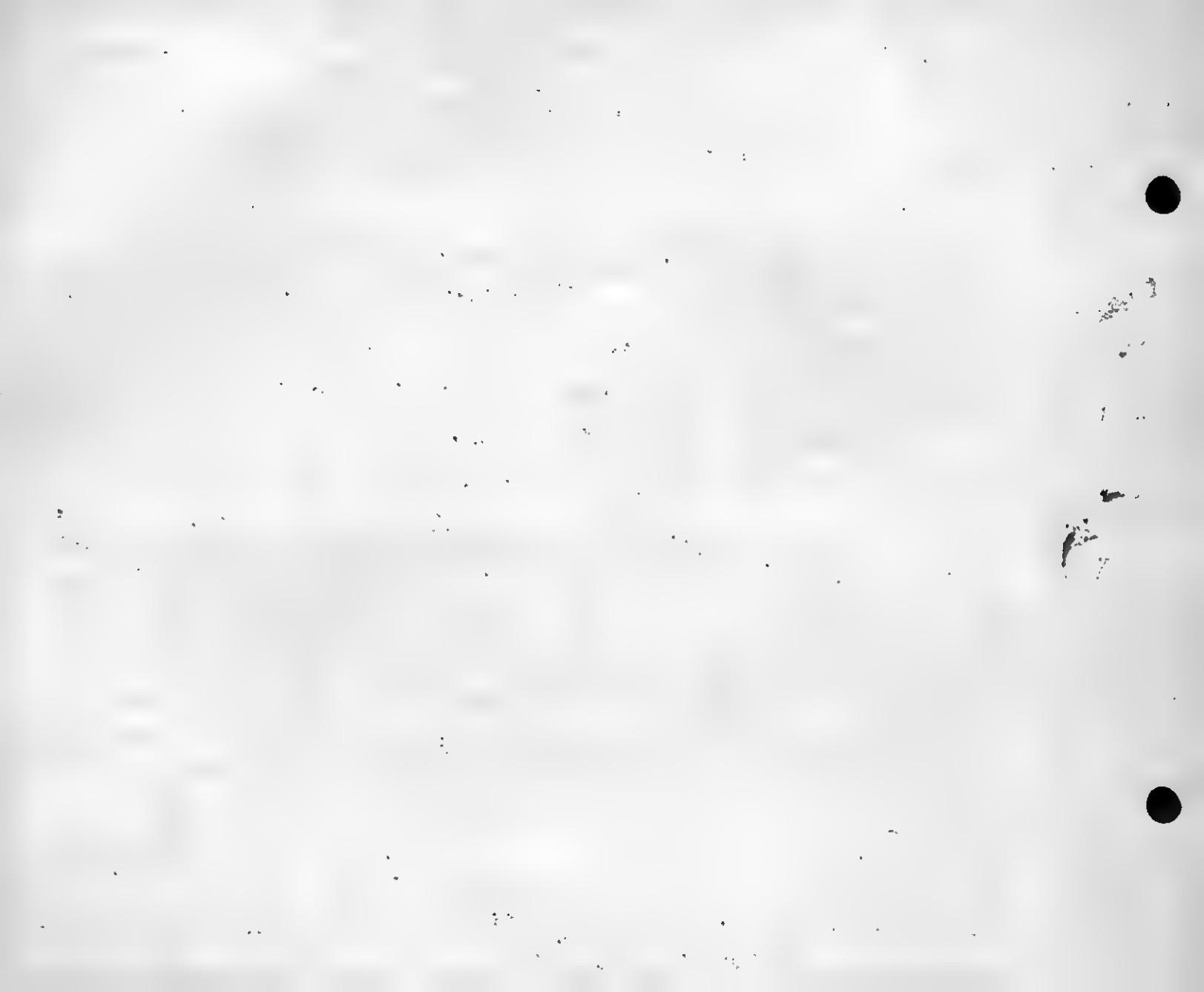
CERTIFICATE OF DEATH

14599

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be removed carbon paper pages 1 and 2 (detached, page 3 should be detached for use as the burial-transit permit. This certificate, page 3 should be detached for use as the burial-transit permit. This certificate, page 3 should be detached for use as the burial-transit permit. This certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First HALLIE	Middle LEE	Last DASHIELL	2a. DATE OF DEATH Month October	Day 16	Year 1968	2b. HOUR 9 A.M.		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 1-11-92		6. AGE (in years last birthday) 76 1/2 yrs.		7. IF UNDER 1 YEAR MONTHS 0		8. IF UNDER 24 HRS. HOURS 0	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? American	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address). Washington Sanatorium Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none		12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Takoma Park	13c. CITY OR TOWN Takoma Park	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 407 Browning Court					
14. FATHER'S NAME First Robert	Middle Hornsby	Last	15. MOTHER'S MAIDEN NAME First Florence	Middle	Last Willing				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 215-54-8309	17. INFORMANT Hospital Records	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4101 CARDIAC ARREST							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ACUTE MYOCARDIAL INFARCT (36 hrs.)									
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISSECTION (See years)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHF, Diabetes mellitus, Oliguria 3° to shock.									
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 10-14-1968 to 10-16-1968 , that (I) (we) last saw the deceased alive on 10-16-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE John L. Ford MD				DEGREE <input checked="" type="checkbox"/> MED. ATTENDING PHYS. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10-16-68				
22d. PHYSICIAN'S NAME (Type) JOHN Louis FORD, M.D.	22e. ADDRESS 831 UNIVERSITY BLVD E. SILVER SPRING, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-18-1968	23c. NAME OF CEMETERY OR CREMATORIAL MANGIN PRES. CEM	23d. LOCATION (City or Town) PRINCESS ANN, MARYLAND	(County)	(State)				
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.	ADDRESS 821 University Blvd E.	25a. REC'D BY REGISTRAR DATE OCT 23 1968	25b. REGISTRAR'S SIGNATURE John L. Ford						
VR A5 30M REV 02									

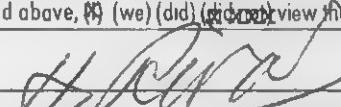
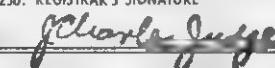


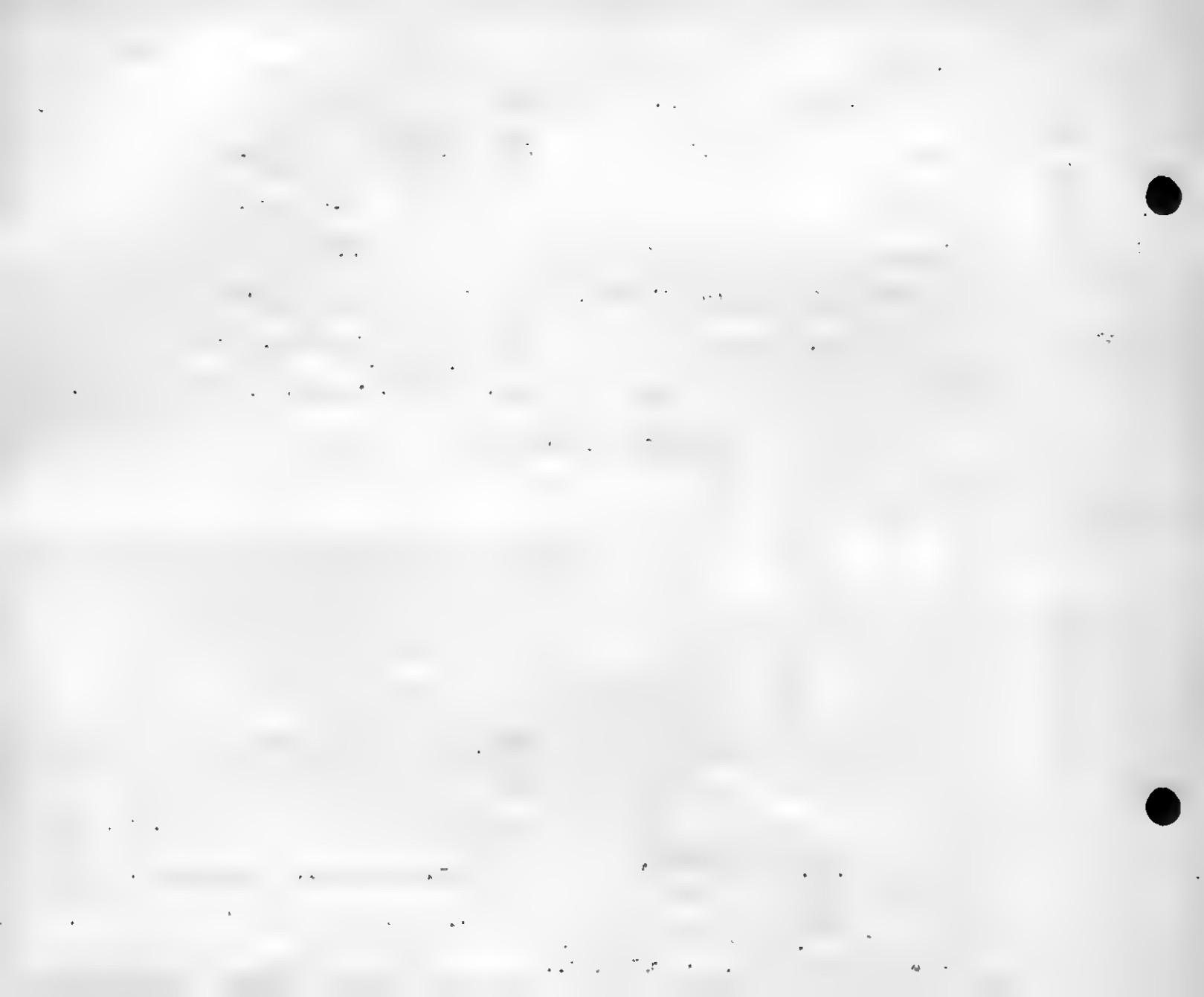
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper [ages] and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)		First Helen	Middle H.	Lost	2a DATE OF DEATH Month OCT	2b HOUR 68 925PM	
3. SEX Female		4 RACE Caucasian	5 DATE OF BIRTH 1898 July 28, 1968	6 AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR MONTHS 0	IF JUNIOR 24 HRS. DAYS 0	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY Md.	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c CITY OR TOWN Anne Arundel	13d INSTN CITY LIM TST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 35 Southgate			
14 FATHER'S NAME Thomas H. Hunt		15. MOTHER'S M AIDEN NAME Beulah Elizabeth Haines					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO.	17. INFORMANT Annapolis		Address Col. Merle B. Dawson, 35 Southgate Ave.	Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Intestinal Hemorrhage					
		DUE TO, OR AS A CONSEQUENCE OF (b)					
		DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERformed		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 3, 1968 , to October 17 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 17 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death							
22b. SIGNATURE 		DEGREE CDR MC USN	ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED Oct. 18, 1968	
22d. PHYSICIAN'S NAME (Type) H. M. RIVAS CDR MC USN		22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-21-68	23c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery		23d. LOCATION (City or Town) Arlington	(County) Va.	
24. FUNERAL DIRECTOR John M. Taylor Funeral Home 147-149 Gloucester St. Annapolis, Md.			25a. REC'D BY REGISTRAR DATE OCT 22 1968		25b. REGISTRAR'S SIGNATURE 		



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the burial permit. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14593

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14601

1 DECEASED NAME (Type or Print)		First	Middle	Lost	2a DATE KNOWN OF EST. DEATH MATED	Month	Day	Year	2b HOUR
<i>Hermayne Norma Sleep</i>					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10/28 128 P.M.
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	8 MARRIED WIDOWED X	NEVER MARRIED DIVORCED	9 COUNTY OF DEATH	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
F	W.	Feb 21, 1901	67 yrs.		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Montgomery	Oct. 27 1968 6 PM	
7a BIRTHPLACE (State or foreign country) W. Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED WIDOWED X		9 COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5815 Kingswood Rd.		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Inspector-Govt		12b. KIND OF BUSINESS OR INDUSTRY Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY (IM 152) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5815 Kingswood Rd.	
14. FATHER'S NAME First Middle Lost		15. MOTHER'S MAIDEN NAME First Middle Lost							
Claude L. Starnes		Carrie E. Hill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO		17 INFORMANT Brother		ADDRESS Julian Starnes- Same as Item 13.			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Intra-cerebral hemorrhage, left, massive.</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral arteriosclerosis & hypertension.</i>		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) JOHN G. BALL		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Oct 28, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-21-68		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington Natl Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia		23e. ADDRESS (Street, city, town, or county) Bethesda, Md.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D BY REG STRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

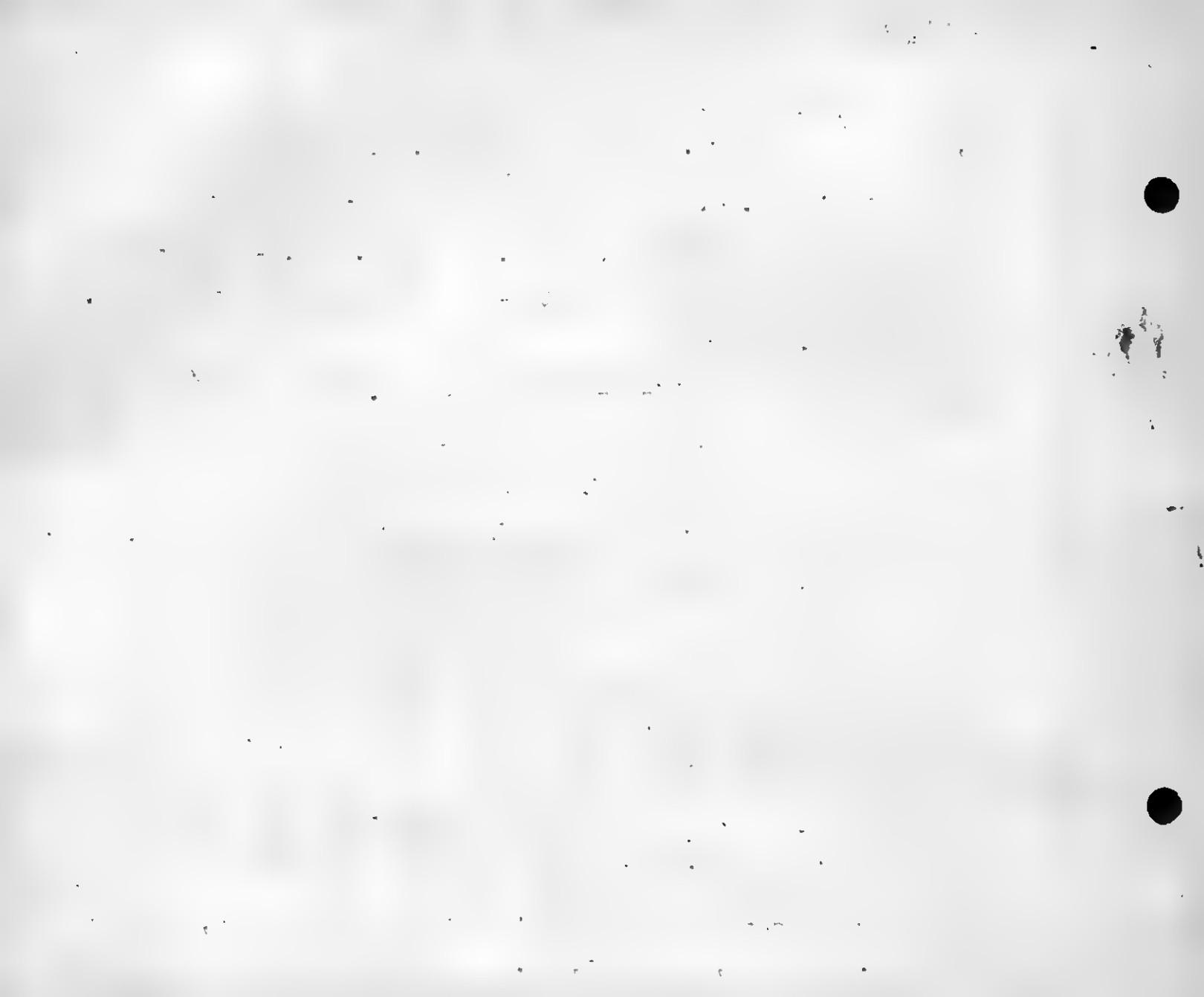
14594

14602

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, seal and sign it. Then please remove carbon papers from page 3 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>John A. Dickinson</i>	Middle	Last	2a. DATE OF DEATH Month <i>October</i>	Year <i>1968</i>	2b. HOUR <i>9:50 P.M.</i>
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH Sept. 4, 1889		6. AGE (in years last birthday) 79	7. IF UNDER 1 YEAR MONTHS YRS.	8. IF UNDER 24 HRS. DAYS HOURS M.N.
7a. BIRTHPLACE (State or foreign country) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5525 Charles St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mech. Eng. - Retired	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5525 Charles St.		
14. FATHER'S NAME First John W. Dickinson	Middle	Last	15. MOTHER'S MAIDEN NAME First Frances M. Dickinson	Middle	Last Foster	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 213-42-7610	17. INFORMANT Wife	Address Same as Item 13		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pulmonary edema, acute</i> 6 hours <i>7/17</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause congestive cardiac failure 1 week stating the underlying cause atherosclerotic cardiac disease 7+ years						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4344 Diabetes mellitus						
19a. DATE OF OPERATION MEDICAL CERTIFICATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) White	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (the hospital) attended the deceased from 1938 , to Oct. 4 , 1968, that (I) (we) last saw the deceased alive on Oct. 4 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Alban W. Eger, M.D.</i>	Degree M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/14/1968	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 1801 Eye St. N.W., Washington					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 10-5-68	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory	23d. LOCATION (City or Town) Suitland, Maryland	(County)	(State)	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.	ADDRESS	25a. REC'D BY REGISTRAR OCT 11 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



14603

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR AM PM
Frederick BABY/BOY	Edward		Doebler	October	12	1968	4:15 P.M.
3 SEX 1 MALE	4 RACE WHITE		S. DATE OF BIRTH October 10, 1968	6 AGE (In years last birthday) MONTHS DAYS HOURS MINUTES			
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9 COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Olney	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none				12b. KIND OF BUSINESS OR INDUSTRY none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Derwood	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 7617 Dew Wood Drive			
14 FATHER'S NAME Charles	First	Middle	Last	15 MOTHER'S MAIDEN NAME Marilyn	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no.	16b. SOCIAL SECURITY NO.	17 INFORMANT Address Admission Rec'd., Montgomery General Hospital					
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhagic meningitis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>742 X</u> <u>Hydrocephalus - congenital</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hydrocephalus - congenital</u> (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u></u>							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 10, 1968</u> to <u>Oct. 12, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct. 12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Katherine A. Chapman, M.D.</u>				DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>Oct. 12, 1968</u>
22d. PHYSICIAN'S NAME (Type)		<u>Katherine A. Chapman</u>		22e. ADDRESS <u>3934 Bladensburg Ave., Kensington Md.</u>			
23a. BURIAL/CREMATION REMOVAL (Specify)		23b. DATE <u>10.15.68</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>U.S. Md. Med. School</u>	23d. LOCATION (City or Town) <u>Baltimore, Md.</u>	(County)	(State)	
24. FUNERAL DIRECTOR <u>Clarendon 31 Rockville Rd</u>		ADDRESS <u>TYSON WHEELER ROCKVILLE, MD.</u>	25a. REC'D. BY REGISTRAR DATE <u>OCT 22 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 1, 2 and 3 to the Chief Medical Examiner's Office alone, with form page 1 and 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office alone, with form page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

14596 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14604

1 DECEASED NAME (Type or Print)	First <i>JESSE</i>	Middle <i>George</i>	Last <i>DORSEY</i>	2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year DEATH ESTI. MATED <input type="checkbox"/> Oct 12 1968 8:20 PM	2b HOUR 8:20 PM			
3 SEX <i>M.</i>	4 RACE <i>Negro</i>	5 DATE OF BIRTH <i>MAY 31-09</i>	6 AGE (in years last birthday) <i>59 yrs</i>	F UNDER 1 YEAR MONTHS <input type="checkbox"/>	IF UNDER 24 HRS DAYS <input type="checkbox"/>	HOURS <input type="checkbox"/>	2c DATE PRONONCED DEAD Month Day Year <i>Oct 12 1968 8:30 AM</i>	2d HOJR 2nd M
7a BIRTHPLACE (State or foreign country) <i>Gaithersburg Md.</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>					
10 CITY OR TOWN OF DEATH <i>Germantown</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Highway 70 S.</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>BTC Railroad Retired</i>	12b KIND OF BUSINESS OR INDUSTRY <i></i>					
13a USUAL RESIDENCE (Where deceased resided at time of death before admission) STATE <i>Maryland</i>	13b CITY OR TOWN <i>Montgomery Gaithersburg</i>	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>Rt. # 3</i>					
14 FATHER'S NAME First <i>JOHN</i>	Middle <i>H.</i>	Last <i>DORSEY</i>	15 MOTHER'S MAIDEN NAME First <i>Dora</i>	Middle <i></i>	Last <i>Payne</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	16b SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT <i>MARIAN DORSEY</i>	319 1/2 ADDRESS <i></i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple Injuries Severe -</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>14.7</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i>		
(b) <i>Trauma from being struck by Auto -</i> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1134</i>								
19a MEDICAL CERTIFICATION DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>Highway</i>		21b TIME OF INJURY Month, Day, Year HOUR <input type="checkbox"/> AM <i>8:30 PM Oct 12 1968</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Pedestrian. Stuck by car on Highway</i>				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> <i>Highway</i>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>		21f LOCATION Street or RFD No City or Town <i>Highway 70 S Germantown Montgomery Md.</i>				
22o. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						22d DATE SIGNED <i>Oct 12, 1968</i>		
ACTUAL SIGNATURE <i>John G. Bell</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>Gaithersburg, Montg., Md.</i>				
23a BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>10-16-68</i>		23c NAME OF CEMETERY OR CREMATORIAL Emory Grove Cem.		23d LOCATION (City or Town) (County) (State) <i>Gaithersburg, Montg., Md.</i>		
24 FUNERAL DIRECTOR <i>Robert L. Snowden Rockville, Md.</i>		ADDRESS		25a REC'D BY REG STAR DATE <i>OCT 15 1968</i>		25b REG'D STAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please send 2 copies to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Done. Dr. John B. Capone Notified and Approved

1. DECEASED-NAME (Type or print)	First Bessie	Middle Catherine Catherine	Lost	2a. DATE OF DEATH Month Day Year October 6 1968	2b. HOUR 14 ⁵⁹ PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH Dec 20, 1899	6. AGE (in years last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Garrett, Ill.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) West San & Hospital	12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Ill.	13c. CITY OR TOWN Champaign	13d. INSIDE CITY LIMITS? YES NO <input type="checkbox"/>	13e. STREET AND NUMBER 1303 South Elm Street		
14. FATHER'S NAME First Marion	Middle Revell	15. MOTHER'S MAIDEN NAME First Lucy	Middle Reeves	lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 337-20-8706	17. INFORMANT Hyattsville, Md. Address Don Drago 2100 Charleston Place			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			2 wk		
(b) multiple Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF lost.			6 mo		
(c) Coronary Artery Heart Disease lost.			6 month		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 8/26/68 , 19 68 , to 8/26 , 19 68 , that (I) (we) last saw the deceased alive on 9/26 19 68 , and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Maurice A. Capone, MD		DEGREE ATTENDING PHYS.	22c. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10/7/68	
22d. PHYSICIAN'S NAME (Type) MAURICE A. CAPONE, M.D.		22e. ADDRESS Georgetown Hospital, Wash. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 10, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Rose Lawn Cemetery	23d. LOCATION (City or Town) Champaign, Illinois	(County)	(State)
24. FUNERAL DIRECTOR Carter Coffin Birds	ADDRESS Maryland Warner E. Pumphrey, Inc. 8434 Ga. Ave. Sils. Spgs.	25a. REC'D. BY REGISTRAR OCT 10 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carried to the hospital or attending physician, page 3 should be detached for use as the burial permit. Then please remove carbon papers. If any event, and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 23c Film G406 10/18/68

14606

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 10 AM
George			D	DRECHSLER	Oct 19 1968	10 AM	
3 SEX		4 RACE	5. DATE OF BIRTH		6 AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE		WHITE	6/18/98		70 yrs	IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
Washington, D.C.		U.S.A.					
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban			12a. USLAL OCCUPATION (Kind of work done during most of working life, even if retired) Bull of mines		
Maryland		13c CITY OR TOWN Chewy Chase			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 7420 Lynn Hurst St.	
14 FATHER'S NAME Edward		First	Middle	Last	TS. MOTHER'S MAIDEN NAME Clara	Middle lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 705-05-0175		17 INFORMANT (WIFE) MARGARETTA DRECHSLER - SAME	Address Andrews.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pyelonephritis Uremia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 510 J (b) Acute Pyelonephritis DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE OR CONDITION GIVEN IN PART 1(a) 6000 Coronary Arteriosclerosis, severe							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/22 1968 , to 10/19 1968 , that (I) (we) last saw the deceased alive on 10/18 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H.P. Dorman		22c. DEGREE M.D.	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10/19/68	
22d. PHYSICIAN'S NAME (Type) H.P. DORMAN		22e. ADDRESS 1302 18TH ST. N.W., WASH., D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-22-1968	23c. NAME OF CEMETERY OR CREMATORIAL Olivet Cemetery		23d. LOCATION (City or Town) St. Michaels, Maryland	(County) (State)	
24. FUNERAL DIRECTOR Joseph Gowler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS	25a. REC'D BY REGISTRAR OCT 23 1968		25b. REGISTRAR'S SIGNATURE Charles Ferguson	DATE	
VR A15 (4) 30M REV. 1/68							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201								CERTIFICATE OF DEATH		14607	
1. DECEASED-NAME (Type or print)		First Boy	Middle —	Last Drew	2a. DATE OF DEATH 10 Month 29 Day 1968 Year		2b. HOUR 2:30 PM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10/29/68		6. AGE (in years last birthday) — yrs		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		Md.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) —		12b. KIND OF BUSINESS OR INDUSTRY CPT A 202					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. CITY OR TOWN MONTGOMERY GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1 WATER STREET					
14. FATHER'S NAME First —		Middle —	Last —	15. MOTHER'S MAIDEN NAME First Elaine		Middle —	Last —				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown —		16b. SOCIAL SECURITY NO —		17. INFORMANT MOTHER		Address Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773X DUE TO, OR AS A CONSEQUENCE OF (b) stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 773.0											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) —							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) —		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Joseph Sibley		DEGREE ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED —						
22d. PHYSICIAN'S NAME (Type) —		22e. ADDRESS —									
23a. BURIAL (REMANENTATION, REMOVAL) (Specify) —		23b. DATE 10/29/68		23c. NAME OF CEMETERY OR CREMATORIAL SUBURBAN HOSPITAL		23d. LOCATION (City or Town) Bethesda		(County) Montgomery	(State) M.D.		
24. FUNERAL DIRECTOR MRS. Amelia C. Carter Administrator		ADDRESS —		25a. RECD BY REGISTRAR —		25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 30M REV 10/68		DATE NOV 1 1968		25a. RECD BY REGISTRAR —		25b. REGISTRAR'S SIGNATURE Charles Judge					



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the offending physician ~~and~~ completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14600

CERTIFICATE OF DEATH

14608

1. DECEASED NAME (Type or print)	First Freddie	Middle Hirschel	Last DUKE	2a. DATE OF DEATH Month OCT 6 Day Year 68 140P M	2b. HOUR
3. SEX Male	4. RACE Caucasian	S. DATE OF BIRTH Mar 24, 1934	6 AGE (In years last birthday) 34 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS
7a. BIRTHPLACE (State or foreign country) Louisiana	7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	Mo	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U. S. Navy	12b. KIND OF BUSINESS OR INDUSTRY	Mc	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Louisiana	13b. COUNTY Vernon	13c CITY OR TOWN Leesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER Route 4, Box 112	
14. FATHER'S NAME First Middle Last John H. Duke	15. MOTHER'S MAIDEN NAME First Middle Last Fredda Enoch				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <input checked="" type="checkbox"/> (If yes give rank and dates of service) 1954-68	16b. SOCIAL SECURITY NO. 437 46 9137	17. INFORMANT Navy Records	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) UNDIFFERENTIATED SARCOMA WITH METASTASES					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a). STATING THE UNDERLYING CAUSE (b). DUE TO, OR AS A CONSEQUENCE OF					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)					
21a. DATE OF OPERATION	21b. CONDITION FOR WHICH OPERATION WAS PERFORMED	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. LOCATION Street or R.F.D. No. City or Town County State			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (If this hospital) attended the deceased from August 17, 1968, to Oct. 6, 1968, that (If we) last saw the deceased alive on Oct. 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (not) view the body after death.					
22b. SIGNATURE <i>R. D. Gaskins</i>	DEGREE	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 7 Oct. 1968
22d. PHYSICIAN'S NAME (Type) R. D. GASKINS, M. D.	22e. ADDRESS Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-11-68	23c. NAME OF CEMETERY OR CREMATORIAL Family Cemetery	23d. LOCATION (City or Town) Jasper	(County) Texas	(State)
24. FUNERAL DIRECTOR W. W. Chambers Co.	ADDRESS 1400 Chapin St., N. W. Washington, D. C.	25a. REC'D BY REGISTRAR DATE OCT 10 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



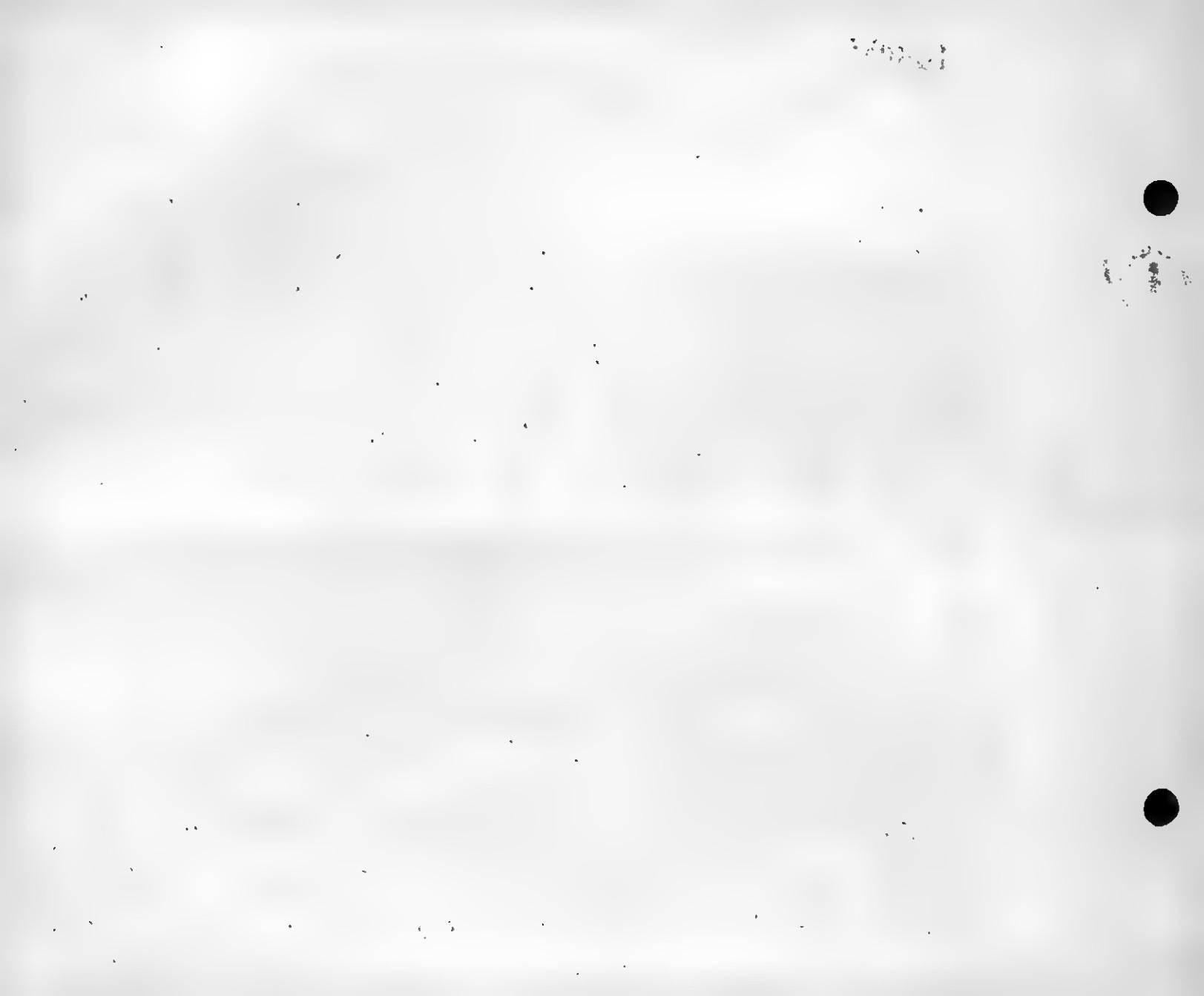
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14609

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

1. DECEASED NAME (Type or print)	First DELLA	Middle NMN	Last DUNHAM	2a DATE OF DEATH 10 Month // Day 68 Year	2b. HOUR 7:30 AM
3. SEX Female	4. RACE CAUCASIAN	S. DATE OF BIRTH 3/18/1933	6. AGE (in years last birthday) 75 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) CANADA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN + HosP,	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Swf		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MIR YLAND	13c. CITY OR TOWN MONTGOMERY TAKOMA PARK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6657 Westmoreland Ave.		
14. FATHER'S NAME First John M. McIntyre	Middle R	Last	15. MOTHER'S MAIDEN NAME Christina	Middle	Last McKenna
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolus</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>i4517</u> (b) <u>Phlebo-thrombosis</u>			Days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>LARCIOMA OF LIVER</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (the hospital) attended the deceased from <u>10-8</u> , 19 <u>68</u> , to <u>10-11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Liam T. Kendall MD</u>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10-11-68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <u>7801 Virginia B. Colmar Manor</u>				
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 15, 1968</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Fort Meade Cemetery</u>	23d. LOCATION (City or Town) <u>Colmar Manor</u>	(County)	(State)
24. FUNERAL DIRECTOR <u>J. Arthur Wallace, 254 Carroll Street HC</u>	ADDRESS <u></u>	25a. REC'D. BY REGISTRAR DATE <u>OCT 15 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14610

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. In any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1	14602			20. DATE OF DEATH Month Oct Year 68	2b. HOUR 8A M	
1. DECEASED-NAME (Type or print)		First LESLIE	Middle L.	Lost EARP		
3. SEX MALE		4. RACE WHITE	S. DATE OF BIRTH 8/13/21	6. AGE (in years last birthday) 47 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH BEVERLYDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Asset Manager		12b. KIND OF BUSINESS OR INDUSTRY Phelps - Roberts
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 4413 HALLET ST.		
14. FATHER'S NAME John N EARP		15. MOTHER'S MAIDEN NAME Bedie		Middle Cornell Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes		16b. SOCIAL SECURITY NO WW II	17. INFORMANT Mildred Earp - wife	Address - same.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 5770 Conditions, if any, which gave rise to immediate cause (a). storing the underlying cause lost. 5870		DUE TO, OR AS A CONSEQUENCE OF Pancreatitis diffuse (b) Pancreatic abscess		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertension and Hemorrhage due to superficial gasous ulceration.						
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Sept 7, 1968, to Oct 3, 1968, that (I) (we) last saw the deceased alive on Oct 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE P.P. Andrews M.D.		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10-3-68	
22d. PHYSICIAN'S NAME (Type) P.P. ANDREWS M.D.		22e. ADDRESS WASHINGTON, D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10-5-1968	23c. NAME OF CEMETERY OR CREMATORIAL FORT LINCOLN CEMETERY	23d. LOCATION (City or Town) BLADENSBURG, PRINCE GEORGE'S	(County)	(State)
24. FUNERAL DIRECTOR JOSEPH WILDER'S SONS, INC., 5130 WILSON AVE. 11 W., N. H., D.C., 20016		ADDRESS	25a. RECD BY REGISTRAR OCT 7 1968	25b. REGISTRAR'S SIGNATURE Charles J. Judge	MD.	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

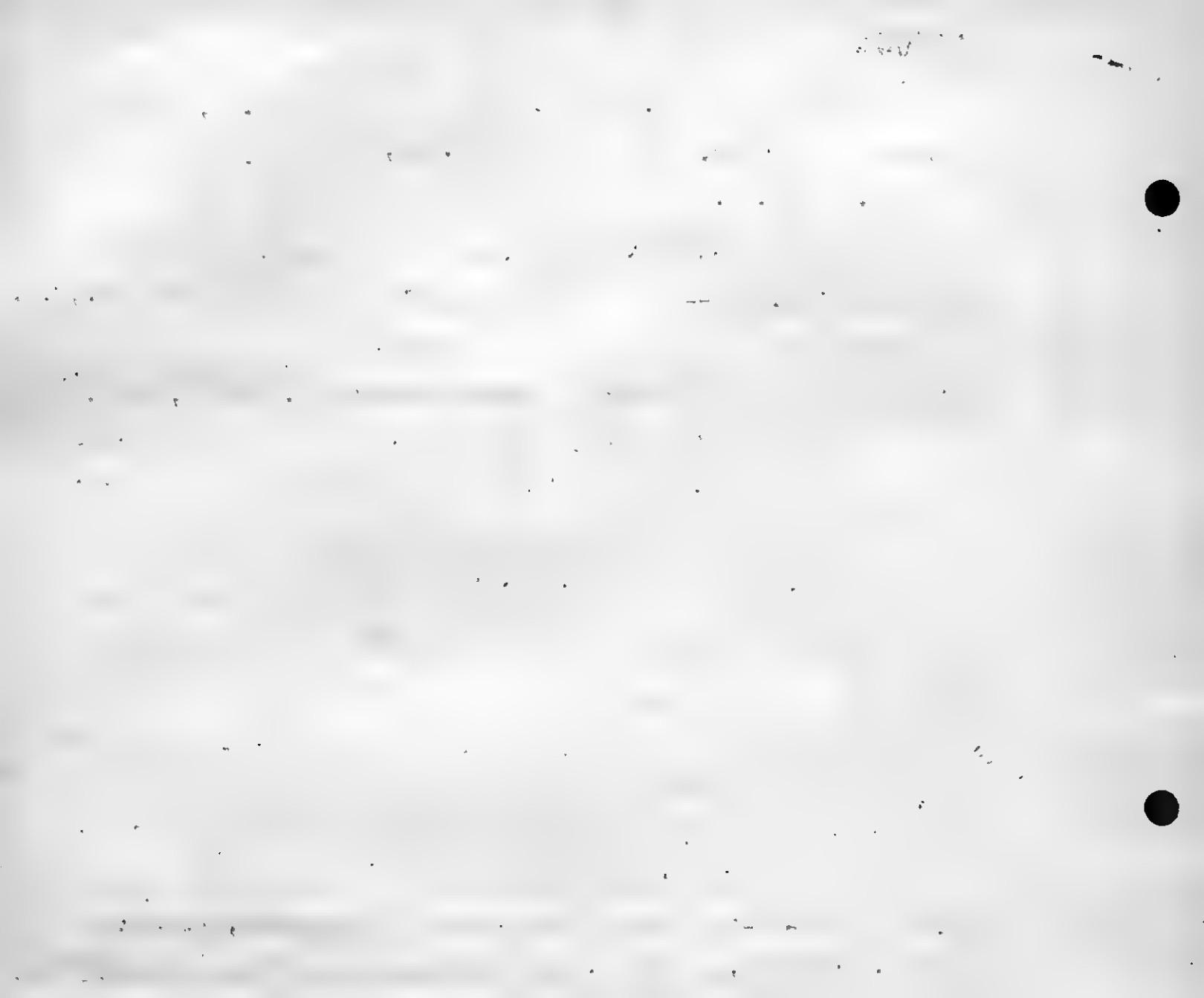
14611

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First INEZ	Middle L.	Last EATON	2a. DATE OF DEATH Month Oct. Day 5, 1968	2b. HOUR Year 8:15 AM
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH Mar. 22, 1879		6 AGE (In years last birthday) 89	IF UNDER 1 YEAR MONTHS YRS
7a. BIRTHPLACE (State or foregn country) Penna.	7b CITIZEN OF WHAT COUNTRY? U. S.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery	IF UNDER 24 HRS MONTHS DAYS HOURS MIN
10. CITY OR TOWN OF DEATH Boyd's	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Boyd's Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE District of Colv	13b. COUNTY --	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER Northampton St., N.W.	
14. FATHER'S NAME First Unknown	Middle	Last	15. MOTHER'S MAIDEN NAME First Unknown	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. Unknown	17. INFORMANT Dorothy Eaton	1550 Sycamore Knolls So. Hadley, Mass.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 492X DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 5571 DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized Arterio Sclerostis					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 1 June, 1966 , to 5 Oct, 1968 , that (I) (we) last saw the deceased alive on 4 Oct 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>Gordon Mardoch Smith MD</i>	22c. DATE SIGNED 5 Oct 68				
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS Barnesville, Md 20703				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 10-7-68	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory	23d. LOCATION (City or Town) Suitland, Maryland	(County) (County)	(State) (State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland	ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland	25a. RECD BY REGISTRAR OCT 9 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14606

14612

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper, page 3, and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>HELEN</i>	Middle <i>E.</i>	Last <i>Egleston</i>	2a. DATE OF DEATH Month <i>10</i>	Day <i>11</i>	Year <i>1968</i>	2b. HOUR <i>3:00 P.M.</i>			
3. SEX <i>FEMALE</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>6-11-76</i>			6. AGE (In years last birthday) <i>92</i>	YRS	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	MIN. <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>Iowa</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	B. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Chevy Chase</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Bethesda - Silver Spring Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Teacher</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Public Schools</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE <i>WASH. DC</i>		13c. CITY OR TOWN <i>WASH. D.C.</i>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	13e. STREET AND NUMBER <i>2853 Ontario Rd, NW</i>				
14. FATHER'S NAME First <i>Henry</i>		Middle <i>Clay</i>	Last <i>Fletcher</i>	15. MOTHER'S MAIDEN NAME First <i>Delta</i>		Middle <i>Anne</i>	Last <i>Camp</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>786-62-3798</i>		17. INFORMANT <i>Mrs. Barbara Horsky</i>		Address <i>1227 Pinecrest Cr S, Silver Spring</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Shudders</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF <i>Chronic arteriosclerotic heart disease, congestive failure</i>										One year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Old healed myocardial infarction</i>										1965	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Generalized arteriosclerosis</i>											
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>At home</i>		21f. LOCATION Street or RFD No <i>—</i>		City or Town <i>—</i>		County <i>—</i>	State <i>—</i>		
22a. I certify that (I) (This hospital) attended the deceased from <i>December, 1950</i> , to <i>Oct. 11, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct. 4, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										22c. DATE SIGNED <i>10-11-68</i>	
22b. SIGNATURE <i>Arnold Mc Nitt, M.D.</i>		DEGREE <i>—</i>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS	22e. ADDRESS <i>1835 Eye St., N.W.</i>							
22d. PHYSICIAN'S NAME (Type) <i>Arnold Mc Nitt</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Crematory</i>			23d. LOCATION (City or Town) <i>Prince George Co., Maryland</i>		(County) <i>—</i>			(State) <i>—</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>Oct. 11, 1968</i>	ADDRESS <i>8434 On Acre</i>			23a. REG'D BY REGISTRAR <i>OCT 16 1968</i>		23b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
24. FUNERAL DIRECTOR <i>Warren K. Lumprey</i>		ADDRESS <i>—</i>			DATE <i>—</i>						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14605

14613

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. In any event, within 24 hours after death, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. DECEASED NAME (Type or print)	First <i>Myles</i>	Middle <i>W. English</i>	Last <i></i>	2a. DATE OF DEATH Month <i>Oct.</i>	Day <i>5</i>	Year <i>1968</i>	2b. HOUR <i>9:53 AM</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>9/29/09</i>	6 AGE (In years last birthday) <i>37 59 yrs</i>	7. UNDER 1 YEAR MONTHS <i></i>	8. UNDER 24 HRS DAYS <i></i>	9. IF UNDER 24 HRS HOURS <i></i>	10. HOURS <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Maine</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Sbarbara Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Highway</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Highway</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13c. CITY OR TOWN <i>Montgomery Bethesda</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>5809 - Wilson Lake</i>					
14. FATHER'S NAME First <i>G. Wesley</i>	Middle <i>English</i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Annie</i>	Middle <i></i>	Last <i>Hempstead</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>MARY English - wife</i>	Address <i></i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Septicemia & Bacteremia</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Diabetes Mellitus</i>								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bacterial Perforated Fistula Left lung</i>							3 days	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pulmonary Abscess Left lung</i>							3 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus</i>								
19a. DATE OF OPERATION <input checked="" type="checkbox"/> MEDICAL CERTIFICATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home Farm, Street, Factory Office Building, Etc.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Oct 5 1968, and that in my (<input checked="" type="checkbox"/> my) (<input type="checkbox"/> my) opinion death occurred on the date and hour and from the causes stated above, (I) (<input type="checkbox"/> did) (<input type="checkbox"/> did not) view the body after death								
22b. SIGNATURE <i>Dewitt E DeLauter MD</i>	DEGREE <input checked="" type="checkbox"/> MED DIRECTOR	ATTENDING PHYS	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>10-6-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>Dewitt E DeLauter</i>	22e. ADDRESS <i>3848 Fletcher St NW Washington DC</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10-8-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>	23d. LOCATION (City or Town) <i>Rockville, Maryland</i>	(County) <i></i>		(State) <i></i>		
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	ADDRESS <i></i>	25a. REC'D. BY REGISTRAR DATE <i>OCT 11 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



18

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

CERTIFICATE OF DEATH

14614

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JAMES STANLEY FALCK							OCT 15 1968	140
3 SEX		4 RACE	5 DATE OF BIRTH			6 AGE "in years lost b. (y)	7 IF UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS. HOURS MIN.
MALE		WHITE	APRIL 13, 1881			87 YRS		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. CITY OF DEATH		
MARYLAND		U.S.A.				MONTGOMERY		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		SUBURBAN			PHARMACIST Ret. Govt			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
STATE MARYLAND		MONTGOMERY		YES		5613 Belmont Ave		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			
FREDERICK				FALCK	MARGARET BERNETTER SHAFFER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
(If yes give war or dates of service)		-		MRS. LAWRENCE Simmons - 4852 Bayaca Blvd		Rockville, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction, septum								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary arteriosclerosis								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) Carcinoma, head of pancreas with metastases to lungs and liver								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Oct 15 1968 , to Oct 15 1968 , that (I) (we) last saw the deceased alive on Oct 15 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (had) (do not) view the body after death.								
22b. SIGNATURE Michael J. Healy MD								
22d. PHYSICIAN'S NAME (Type)		23b. DATE 10-18-1968		23c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery		23d. LOCATION (City or Town) Washington, D.C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-18-1968		23c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery		(County) (State)		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 3130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS		25a. REC'D BY REG. STRR. Oct 21 1968		25b. REGISTER'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil on item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 406 MARYLAND STATE DEPARTMENT OF HEALTH
11-19-68ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14615

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR 168 12:45
PAUL AUGUSTINE FEDERLINE					<input checked="" type="checkbox"/>				
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 6-3-17	6 AGE (in years last birthday) 51	7 IF UNDER 1 YEAR MONTHS YRS	8 IF JUNIOR 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 10	Day 25	Year 1968	2d HOUR 12:45
7a BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY				
10 CITY OR TOWN OF DEATH OLNEY		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MASONRY FOREMAN		12b KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13c CITY OR TOWN MONTGOMERY SILVER SPRINGS		13d INSIDE CITY LIMITS? NO	13e STREET AND NUMBER 1912 NORBECK ROAD				
14. FATHER'S NAME LOUIS		Middle	Last	15 MOTHER'S MAIDEN NAME WILAMINA CRAMER		First	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NC		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT MEDICAL RECORDS		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Bronchopneumonia</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4</i>		DUE TO, OR AS A CONSEQUENCE OF <i>14 days of illness followed by pneumonia</i>							
		DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>491X</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <i>Bedon Reap, M. D.</i>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS Street, City, Town or county <i>Rockville, Maryland</i>		22b. DATE SIGNED <i>10/25/1968</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 10-29-68		23c NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d LOCATION (City or Town) Rockville, Maryland		(County) (State)	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, ROCKVILLE, MARYLAND		ADDRESS		25a REG'D BY REGISTRAR DATE NOV 4 1968		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in at the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14616

I DECEASED-NAME (Type or print) Katherine		First	Middle	Lost	2a. DATE OF DEATH Month OCTOBER Day 14 Year 1968	2b. HOUR 45 p.m.	
3. SEX F	4 RACE W	5 DATE OF BIRTH March 3, 1911		6 AGE (in years last birthday) 57	7 IF UNDER 1 YEAR MONTHS 0	8 IF UNDER 24 MRS. HOURS 0	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosemont San. Bethesda, Md.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Architect		12b. KIND OF BUSINESS OR INDUSTRY Building	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spr.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 711 Dale Drive		
14. FATHER'S NAME Howard	First	Middle	Lost	15. MOTHER'S MAIDEN NAME Cutler	First	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		16b. SOCIAL SECURITY NO 578-03-6484	17. INFORMANT Rudolph W. Ficken	Address Sil. Spr. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Skull and cerebral metastasis DUE TO, OR AS A CONSEQUENCE OF (b) Mammary carcinoma left breast DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN DNST AND DEATH 11 1/2 years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION May 15 '57	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Mammary carcinoma	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING ACCIDENT <input type="checkbox"/> DRIVING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> If either, notify medical examiner	21b. TIME OF INJURY HOUR A.M. 19 Month May Day 1 Year 1957	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) No Injury					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC) No Injury	21f. LOCATION Street or R.F.D. No. 1834 Conn. Ave., N.W.	City or Town Washington, D.C.	County	State		
22a. I certify that (I) (the hospital) attended the deceased from May 1, 1957 , to October 14, 1968 , that (I) (we) last saw the deceased alive on October 14, 1968 , and that in (my) (<input type="checkbox"/> we) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (<input type="checkbox"/> did not) view the body after death							
22b. SIGNATURE Charles F. Geschickter		DEGREE M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED Oct 14 1968	
22d. PHYSICIAN'S NAME Charles F. Geschickter, M.D.	22e. ADDRESS 1834 Conn. Ave., N.W. Washington, D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Casket	23b. DATE 10-17-1968	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery	23d. LOCATION (City or Town) Rockville		(Country) Montgomery		
24. ATTENDING DIRECTOR C. Glen Carter	ADDRESS Warren E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.		25a. RECD BY REGISTRAR DATE OCT 21 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14609

14617

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Oct Month 5 Day Year 1968 11	2b. HOUR M
N. W. Fincham				Fincham		
3. SEX Male		4. RACE White		S. DATE OF BIRTH 6-16-1887	6. AGE (In years last birthday) 81 yrs	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brookgrove Road Brooke Grove Foundation		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Master Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Gov't.
13a. L.S.A. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland		13c. CITY OR TOWN Montgomery Side Soc.		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8614 2nd Avenue	
14. FATHER'S NAME George Clinton Fincham		15. MOTHER'S MAIDEN NAME Weakley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16b. SOCIAL SECURITY NO. 215-462-469		17. INFORMANT Mr. Alvin F. Fincham 3409 Farragut Street		Address Kensington, Md.
						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1547 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)						
19a. DATE OF OPERATION 1/1/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (the hospital) attended the deceased from May 18, 1965, to Oct 8, 1968, that (I) (we) last saw the deceased alive on Oct 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Gene U. Cohen		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Oct 8, 1968.
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 1106 Spring St., Silver Spring, Md.				
23a. BURIAL, CREMATION, BENEFITS (Specify)		23b. DATE 10-11-1968		23c. NAME OF CEMETERY OR CREMATORIAL St. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland
24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc.		ADDRESS 8434 Georgia Avenue		RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 30M REV.		DATE OCT 11 1968				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

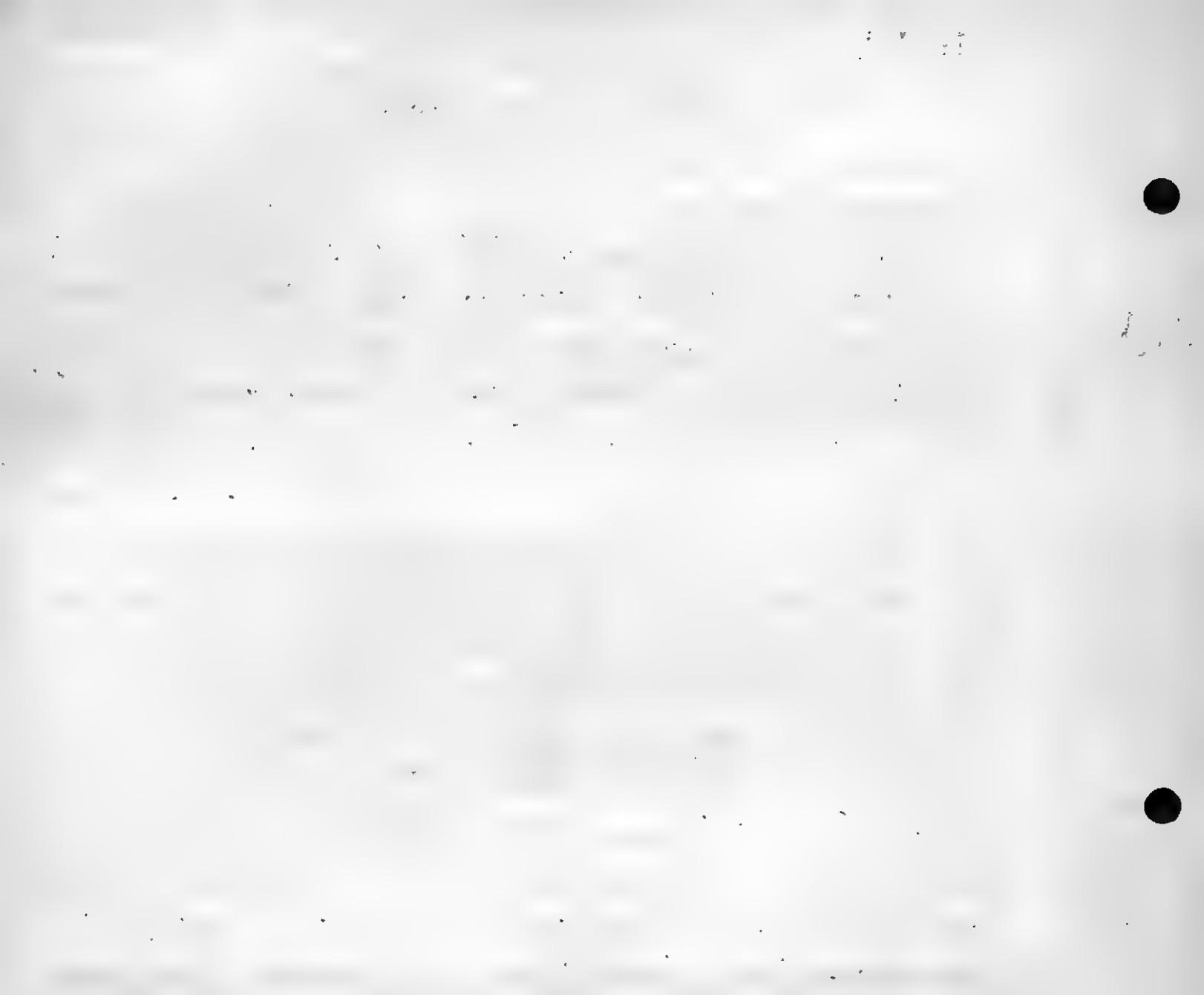
14618

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by him/her.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him/her, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 8 ⁴⁵ /M		
Hester FLORENCE Finkenbinder				10 14 68			
3. SEX F	4. RACE W	S. DATE OF BIRTH 12/20/1895	6. AGE (in years last birthday) 72 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Co.				
10 CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital or street address) Kensington Gardens Sanitarium	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retail Clerk	12b. KIND OF BUSINESS OR INDUSTRY Dept. Store				
13a. U.S./AL RESIDENCE (Where deceased lived, if institution admission) STATE Md.	13b. COUNTY Mont.	13c. CITY OR TOWN Wheaton	13d. INSIDE CTY LIM IS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 11942 Bluhill Rd.			
14 FATHER'S NAME First Samuel	Middle	Last	15 MOTHER'S MAIDEN NAME First Margaret	Middle	Last Rowe		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 591-05-9641	17 INFORMANT GARNETT ABERNATHY	Address WHEATON MD 11942 BLUHILL RD				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carroll Worcester accident							
4561 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Generalized embolism DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None							
19a. DATE OF OPERATION 2/22		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Sept. 12 1968 to Oct. 18 1968 , that (I) (we) last saw the deceased alive on Sept. 12 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John S. Rogers		22c. DATE SIGNED Oct. 18 1968					
22d. PHYSICIAN'S NAME (Type) JOHN S. ROGERS		22e. ADDRESS KENSINGTON, MD					
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) BURIAL	23b. DATE 10/17/68	23c. NAME OF CEMETERY OR CREMATORIAL CHAPEL	23d. LOCATION (City or Town) LIBERTYTOWN	(County) MD	(State)		
24. FUNERAL DIRECTOR DD Hartzler & Sons Union Bridge	ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 18 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14611

CERTIFICATE OF DEATH

14619

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR AM 5:00 M	
Kent			Sheridan	Foster		October	22	1968			
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		22 June 1957			11 YRS.		IF UNDER 24 HRS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
California		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			The Clinical Center, NIH			Student					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Nevada			Clark		Las Vegas		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		300 Fuchsia Circle		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
Robert			E.	Foster		Janice			Hamler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			None			Bethesda, Maryland add 20014			5 Days		
The Medical Records, The Clinical Center											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) Acute Bronchitis											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Bronchiectasis											
BUE TO, OR AS A CONSEQUENCE OF											
(c) Ataxia Telangiectasia											
Years											
Years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 18 Sept. 1968, to 22 Oct. 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 22 October 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE			Dale E. McFarlin	DEGREE	ATTENDING PHYS	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)			The Clinical Center, National Institutes of Health, Bethesda, Maryland								10/22/68
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town)		(County)		(State)
Burial		10-26-68		Woodlawn Cemetery			Las Vegas, Nevada				
24. FUNERAL DIRECTOR		ADDRESS			25a. RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
ROBERT A. PUMPHREY, Bethesda, Maryland							OCT 28 1968			Charles Judge	
VR A15 (4) 30M REV 1/68											



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14620

CERTIFICATE OF DEATH

14612

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 5:55
MARY ELIZABETH FRANCIS		OCT. 10 1968	8 A.M.		
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	2d. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS 8 8 8 AMH.	
FEMALE	W.	2-24-86	82 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	Montgomery	
PENN. AMERICAN		MONTGOMERY		Md.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
TAKOMA PARK	WASH. SAN. & Hospt.			NONE	
13a. USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
MD.	MONTG.	SILVER SPRING	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	11312 Clarendon Dr.	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First Middle Last
CHARLES		GRIM		ANNA	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address		
NO	Not Avail.	CHART.	Washington Sanitarium & Hospital, Takoma Park, Md.		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last). Hypoglycemia Reaction (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Cardiovascular Disease					
19a. DATE OF OPERAT. ON	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Oct. 3, 1968 , to Oct. 14, 1968 , that (I) (we) last saw the deceased alive on Oct. 14, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.					
22b. SIGNATURE Raymond Bradshaw, MD	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Oct. 14, 1968	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS Silver Spring, Md.				
RAYMOND BRADSHAW, M.D.					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10/15/68	23c. NAME OF CEMETERY OR CREMATORIAL Westminster Cemetery	23d. LOCATION (City or Town) Philadelphia,	(County) Pennsylvania.	(State)
24. FUNERAL DIRECTOR ROBERT A. FUMPHREY, Bethesda, Maryland	7557 ADDRESS Wisconsin Ave.	25a. REC'D BY REGISTRAR DATE OCT 18 1968	25b. REGISTRAR'S SIGNATURE Charles J. Judge		

25-12-2

6



6



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14613

14621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with § 721 of the State of Maryland.

1 DECEASED NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
NORMAN D		FRANCIS		10 26 68 5A M	
3 SEX MALE	4. RACE WHITE	S. DATE OF BIRTH JUNE 1-1903	6. AGE (in years last birthday) 60 YRS.		
7a. BIRTHPLACE (State or foreign country) BESSEMER (Pa) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH SILVER SPRINGS		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bellevue Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Montgomery Co. Salesman Clothing	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY WASH		13d. INSIDE CITY, JM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1410-M St. N.W.
14. FATHER'S NAME NOAH D.	First	Middle	Lost	15. MOTHER'S MAIDEN NAME FRANCES CONDRAY	Middle Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown)		16b. SOCIAL SECURITY NO 250-03-9017		17. INFORMANT Helen S. Huer	Address Gastonia, N.C.
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Cerebral Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day	
41d / Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Arterio-venous Malformation		572r	
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from Aug., 1968, to Oct. 20, 1968, that (I) (we) last saw the deceased alive on 10/31/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harold Henger MD		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 10/20/68
22d. PHYSICIAN'S NAME (Type) Harold Henger MD		22e. ADDRESS 5415 Conn. Ave NW DC			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 10-31-1968	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Cemetery		23d. LOCATION (City or Town) Shelby (County) North Carolina (State)
24. FUNERAL DIRECTOR C. E. Johnson, Clarkston L. Sp. Md. 14th & E. P. Avenue, 912, S. 13th Ga. Avenue		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 30 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



Cleared by Dr. B. Reap County Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

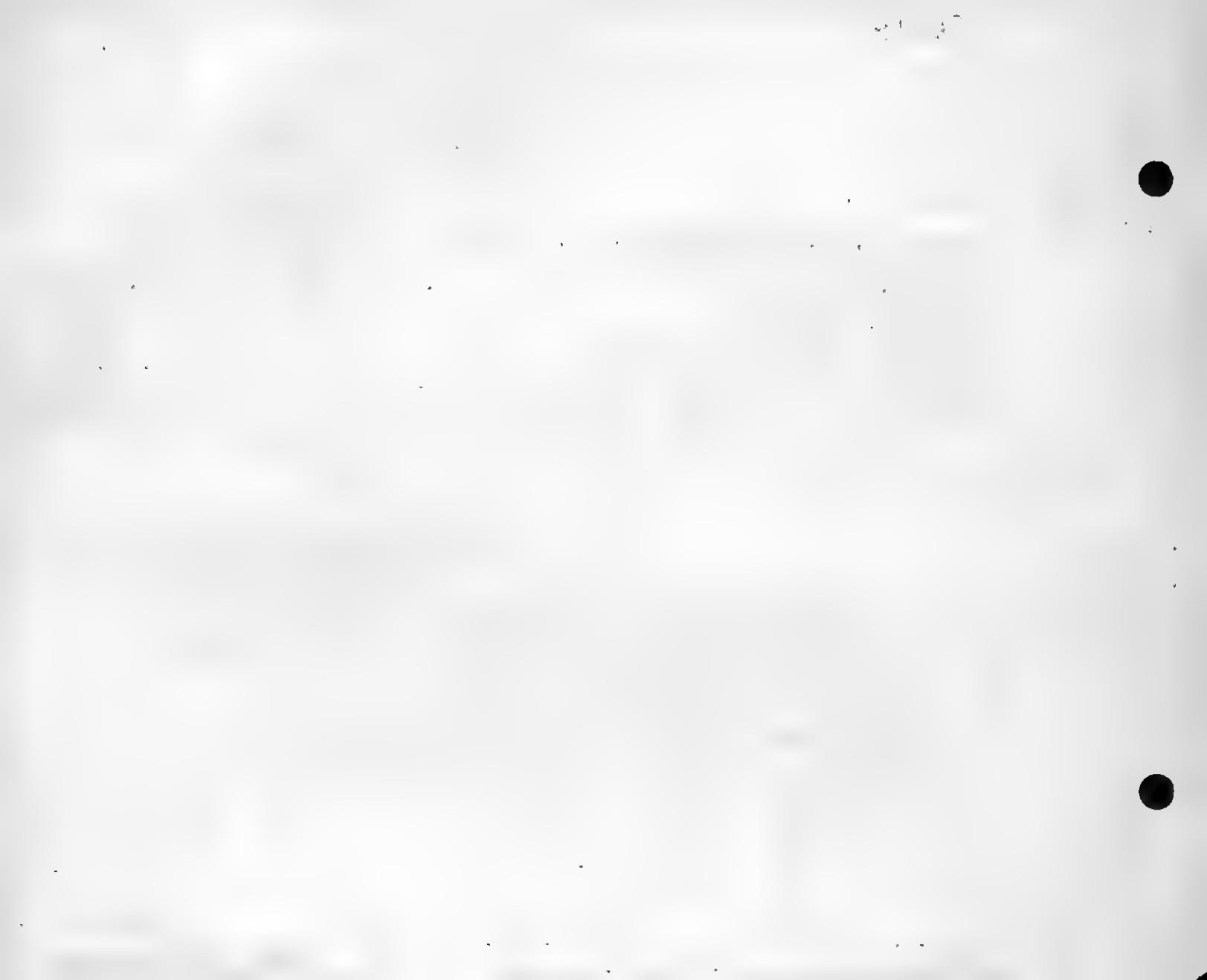
14614

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14622

1. DECEASED-NAME (Type or print)	First James	Middle Archie	Last Furnason	2a. DATE OF DEATH Month 10 30 1968	Day	Year	2b. HOUR 7:26PM
3. SEX Male	4. RACE W	5. DATE OF BIRTH 10-1-95			6 AGE (in years last birthday) 83 yrs	F UNDER 1 YR MONTHS	IF UNDER 24 HRS HOURS
7a. BIRTHPLACE (State or foreign country) Oneonta, N.Y.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Montgomery			Md
10. CITY OR TOWN OF DEATH Montgomery Park, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter			12b. KIND OF BUSINESS OR INDUSTRY Construction
13a. USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE N.Y.	13b. COUNTY Montgomery	13c. CITY OR TOWN Tak. Park	13d. INSIDE CITY LIMITS X Yes □ No □	13e. STREET AND NUMBER 7346 Carroll Ave.			
14. FATHER'S NAME First Stewart Middle Curtis E. Furnason	15. MOTHER'S MAIDEN NAME First Synthia Kathryn			Middle Bedine	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown	16b. SOCIAL SECURITY NO 297-01-8809	17. INFORMANT Margaret E. Furnason	Address Tak. Park, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Osteosclerotic Cardiovascular Disease</i>							
4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Generalized Osteoarthritis</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Anemia in abdominal area</i>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 1957 to Oct 30, 1968, that (I) (we) last saw the deceased alive on Aug 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Richard L. Whelton</i>	22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS.	22d. DATE SIGNED Oct 30, 1968					
22d. PHYSICIAN'S NAME (Type) Richard L. Whelton, M.D.	22e. ADDRESS 1017 University Blv. East, S.S. Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 11-2-1968	23c. NAME OF CEMETERY OR CREMATORIAL Partlawn Cemetery	23d. LOCATION (City or Town) Rockville	(County) Montgomery	(State) Md		
24. FUNERAL DIRECTOR Name <i>Charles J. Lee</i>	ADDRESS <i>Sil. Sp. Rd.</i>	25a. RECD BY REGISTRAR Date <i>NOV 7 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Lee</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14623

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)		First Eula	Middle Blanche	Last Gardner	2a DATE OF DEATH Month October	Day 13, 1968	2b HOUR 2:35 P.M.
3 SEX Female	4 RACE White	5. DATE OF BIRTH January 7, 1880		6. AGE (in years last birthday) 88 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0
7a BIRTHPLACE (State or foreign country) TENN.	7b. CITIZEN OF WHAT COUNTRY? America	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		
13a USA, RESIDENCE (Where deceased lived, if institution: Residence before admission) Washington D.C.		13c. CITY OR TOWN D.C. N.W.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/>	13e STREET AND NUMBER 2039 New Hampshire ave		
14 FATHER'S NAME ALLEN	First ALLEN	Middle TATE	Last ARIANNA	MIDDLE PECK	LAST SIL. SPC #10		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no	16b. SOCIAL SECURITY NO (If yes give no. or date of service) UNKNOWN	17 INFORMANT BERNARD HELEN			Address 8602 SURINAME DR		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Pneumonia Approximate interval between onset and death 3 days							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. congestive Heart Failure							
Due to, or as a consequence of (b) congestive Heart Failure							
Due to, or as a consequence of (c) Pulmonary Embolism							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Recent, cerebral vascular accident (2) Atrial fibrillation (3) Chronic Bronchitis (4) Syndrome							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State		
22a. I certify that (1) (this hospital) attended the deceased from 10-10, 1968 , to 10-13, 1968 , that (1) (we) last saw the deceased alive on 10/13/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.							
22b. SIGNATURE Alan R. Gair				DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. DATE SIGNED 10/13/68				22e ADDRESS 3118 Craigmaw Rd, Beltsville, Md			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 10-15-68	23c. NAME OF CEMETERY OR CREMATORIAL GLENWOOD CEM.	23d LOCATION (City or Town) BALTIMORE, MD	(County) Wash., D.C.	(State)		
24 FUNERAL DIRECTOR W.C. CHAMBERS	ADDRESS 1400 CHAPIN ST. N.W. WASH. D.C.	25a. REC'D BY REGISTRAR DATE OCT 15 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14624

14616

CERTIFICATE OF DEATH

See Attached ninth matching statement

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and 2 pages 1 and 2 after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR Min
Thomas F. Garey III				Garey	Oct 5 1968	4:30
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	F UNDER 1 YEAR MONTHS DAYS HOURS MIN	F UNDER 24 HRS
Male	White	Nov 8, 1910		57 yrs		
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Bethesda MD	U.S.A.			Montgomery Md		
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY	
Bethesda	Suburban Enginner			Engineer	Engineering	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INS DE CITY JUN 1968 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	912 Twinbrook Plaza	
Md.	Montgomery	Twinbrook				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle
Thomas F. Garey III				Edith Estelle Cole		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. Name - Social Security No.	17 INFORMANT	Address			
Yes	44-39416-038638	Lucille Heller Garey	1526 Parkside			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						
Myocardial infarction						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH none						
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery thrombosis						
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary arteriosclerosis						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (his hospital) attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>Oct 5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug. 23 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Seruch T. Kimble		MD DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10-5-68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 9801 Georgia Ave., Silver Spring, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-9-68	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Natl Cem.	23d. LOCATION (City or Town) Baltimore, Maryland (County) (State)		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR OCT 11 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, then please remove carbon paper pages 1 and 2. Director page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2. Director page 3 should be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2. Director page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

14617

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 16b FilmG405 CERTIFICATE OF DEATH

14625

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR AM. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. PM. IF UNDER 24 HRS.			
George Washington Garland				10	6	68	10:50 AM			
3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. BIRTHPLACE (State or foreign country)	8. CITIZEN OF WHAT COUNTRY?	9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Male	White	June 29, 1892	76 yrs.	Washington DC.	U.S.A.	Silver Spring	3650 Glen Eagles Dr.	Glen Eagles Dr.	Cartographic Eng.	U.S. Geological Survey
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Md.	Montgomery	Silver Spring	3650 Glen Eagles Dr.	Jefferson D. Garland	Margaret	Hempill				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	16c. INFORMANT	16d. ADDRESS	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.	DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)	Cerebral Thrombosis Arteriosclerosis, severe	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days years.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 327x										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State					
22a. I certify that (I) (this hospital) attended the deceased from Nov. 19 66, to Oct. 6, 1968, that (I) (we) lost saw the deceased alive on 10/6/68 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Richard A. Yates, M.D.	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10/7/68					
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 3701 Rossmoor Blvd., Sil. Sp., Md.									
23a. BURIAL... CREMATION. BURIAL (Check if applicable)	23b. DATE 10-10-1968	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sil. Spr. Md.	23d. LOCATION (City or Town) (County) (State) Prince Georges, Md.							
24. FUNERAL DIRECTOR Warren Carter Casket Sales Inc.	ADDRESS 8434 Georgia Avenue		25a. REC'D BY REGISTRAR DA OCT 8 1968	25b. REGISTRAR'S SIGNATURE Charles Judge						



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14618 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14626

1 DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b HOUR	
<i>Grose</i>				<input checked="" type="checkbox"/>	Oct	2	1968	7 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS				
Female	White	5/18/13	55 yrs.	MONTHS	DAY	HOURS	MIN.		
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	2c DATE PRONOUNCED DEAD				2d HOUR
<i>Oregon</i>	USA			<i>Montgomery</i>	Month	Day	Year		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)				12b KIND OF BUSINESS OR INDUSTRY
<i>Bethesda</i>	<i>Auburnton</i>				<i>Housewife</i>				
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE	13b COUNTY	13c CITY OR TOWN	3d INSIDE CITY LIMITS	13e STREET AND NUMBER					
<i>Md</i>	<i>Mont</i>	<i>Bethesda</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>4506 Cheltenham</i>					
14. FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last		
<i>Joseph</i>			<i>Grosdale</i>	<i>Wilhelmenia</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO	17 INFORMANT	Husband	ADDRESS					
No	None	<i>Anthony A. Gleisner</i>	<i>Anthony A. Gleisner</i>	<i>Name as above</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Septicemia</i>								<i>1 week.</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Decubitus Ulcers of hips, infected</i>								<i>2 months</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Fracture of Right Hip</i>								<i>5 months</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Multiple Sclerosis</i>									
19a. DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY?			
<i>May 7, 1968</i>		<i>Nothing of fracture of Rt hip</i>				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State					
		<i>Home</i>		<i>4506 Cheltenham D. Bethesda Mont. Md.</i>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John G. Ball</i>								CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
M.D.								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ADDRESS (Street, city, town, or county)								22b DATE SIGNED <i>Oct. 3, 1968</i>	
<i>Bethesda, Md.</i>									
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORIAL				23d LOCATION (City or Town)	(County)	(State)	
Burial	10-5-68	<i>Gate of Heaven Cem.</i>				<i>Silver Spring, Md.</i>			
24 FUNERAL DIRECTOR	ADDRESS				25a REC'D BY REG STRAR	25b REGISTRAR'S SIGNATURE			
<i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>						<i>Charles Judge</i>			
VR AT5ME (5) 10M REV 1/68					DATE	OCT 7 1968			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

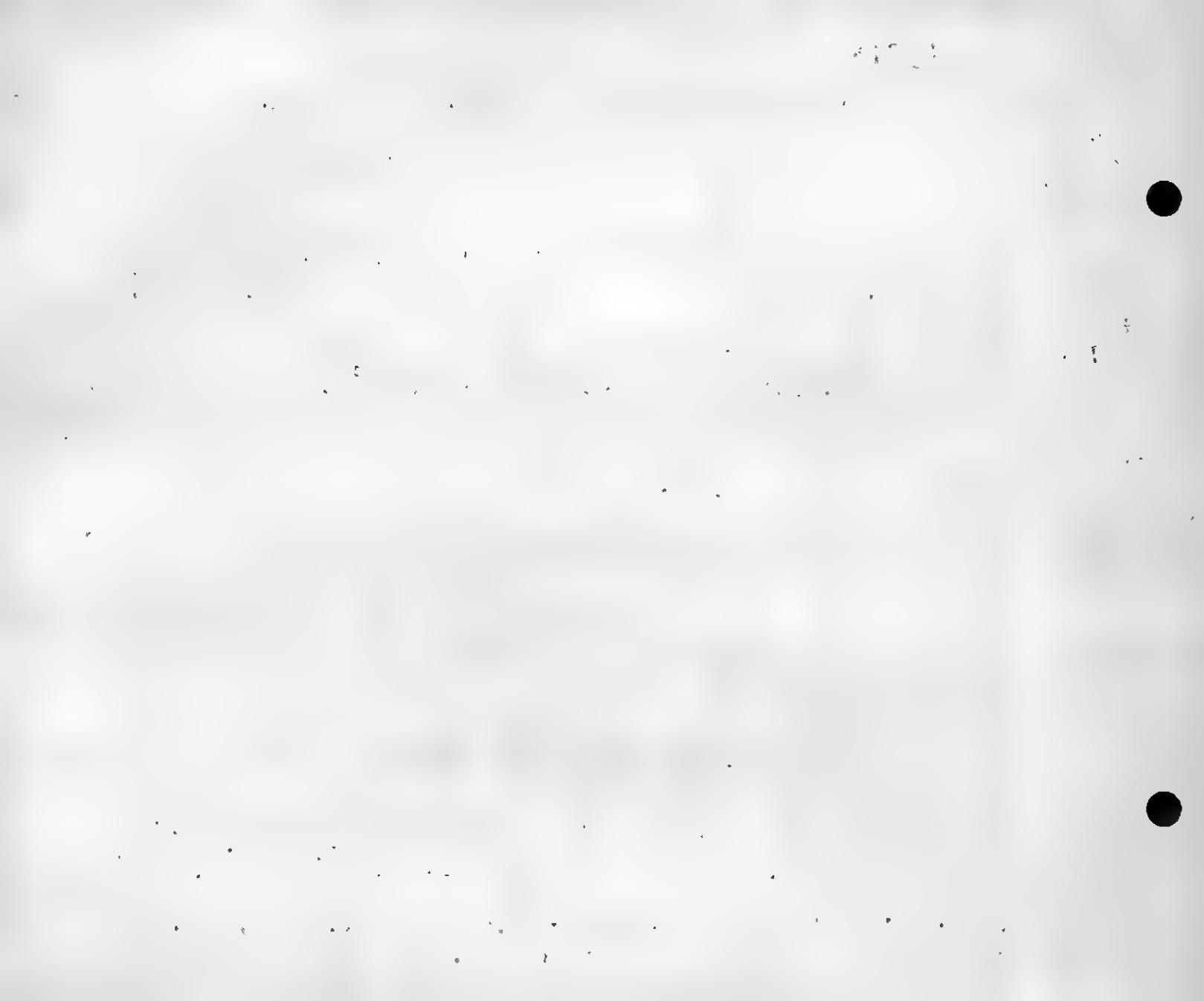
14627

14615

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with 72 hours after death.

1. DECEASED-NAME (Type or print)			First Cecil	Middle Lamont	Last Gingerich	2a. DATE OF DEATH Month October	Day 16	Year 1968	2b. HOUR M 11:55
3. SEX Male		4 RACE White	5 DATE OF BIRTH 21 June 1921			6 AGE (in years last birthday) 47	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	2b. HOUR H MIN. 00
7a. BIRTHPLACE (State or foreign country) Iowa		7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Investments			12b. KIND OF BUSINESS OR INDUSTRY Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Florida		13c. CITY OR TOWN Sarasota			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 7606 Peninsula Drive			
14 FATHER'S NAME Arthur		First C.	Middle Gingerich	Last	15. MOTHER'S MAIDEN NAME Vina			16. LOST Yoder	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 1944-1946			17. INFORMANT The Medical Record Address Not available The Clinical Center, NIH, Bethesda, Maryland			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sepsis - Shock (b) Pneumonia, Bilateral (c) Acute Myelogenous Leukemia									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia, Bilateral (c) Acute Myelogenous Leukemia									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 2042		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20d. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September, 19 68 , to 16 Oct., 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 16 October 19 68 , and that in (My) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> view the body after death.									
22b. SIGNATURE <i>Brian W. Goodell M.D.</i>		DEGREE M.D.			ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/17/68	
22d. PHYSICIAN'S NAME (Type) Brian W. Goodell, M. D.		22e ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-19-68	23c. NAME OF CEMETERY OR CREMATORIAL Sarasota Mem. Park			23d. LOCATION (City or Town) Sarasota, Florida	(County)	(State)	
24. FUNERAL DIRECTOR Everly-Wheatley Funeral Home		ADDRESS			25a. REC'D. BY REGISTRAR OCT 23 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14628

1. DECEASED-NAME (Type or Print)	First NATHANIEL	Middle GLASSER	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month Oct	Day 15	Year 1968	2b. HOUR 12 PM				
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 5/4/1885	6. AGE (In years last birthday) 83 YRS	IF UNDER 1 YEAR MONTHS 83	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month Oct	Day 15	Year 1968	2d. HOUR 30 12 PM	
7a. BIRTHPLACE (State or foreign country) N.Y.	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY									
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 8803 WALNUT Hill Road								
14. FATHER'S NAME First ABRAHAM.	Middle GLASSER	Last	15. MOTHER'S MAIDEN NAME First REBECCA									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO 577-07-1343	17. INFORMANT Mrs Sidney Schuman - Daughter	ADDRESS Same AS.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			Coronary Insufficiency Acute - Arterio Sclerosis Generalized -			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days.						
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						years.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture of Rt. Hip.												
19a. DATE OF OPERATION 10/9/68.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Repair of fracture of Rt hip.			20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR 4 PM Oct 4 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fall in bath room.								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Nursing Home		21f. LOCATION Street or R.F.D. No Kensington Nursing Home. Kensington. Mont. Md.		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Oct. 15, 1968.			
EXAMINER'S NAME (Type) JOHN G. BALL		M.D.			ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10-17-68		23c. NAME OF CEMETERY OR CREMATORIUM ADAS ISRAEL CEMETERY		23d. LOCATION (City or Town) WASHINGTON DC		(County)		(State)		
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS - WASHINGTON DC		ADDRESS		25a. RECD BY REGISTRAR OCT 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14629

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 days after death.

1 DECEASED NAME (Type or print)	First <i>Grace</i>	Middle <i>M.</i>	Last <i>Gleason</i>	2a. DATE OF DEATH Month <i>Oct</i>	Day <i>24</i>	Year <i>1968</i>	2b. HOUR 30 2 H. M.	
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>Feb 3 1888</i>		6 AGE (in years last birthday) <i>80 yrs.</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	E UNDER 24 HRS DAYS <i>0</i>	HOURS <i>0</i>	MIN <i>0</i>
7a BIRTHPLACE (State or foreign country) <i>ILLINOIS</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>MONTGOMERY</i>	Md				
10 CITY OR TOWN OF DEATH <i>KENSINGTON</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kensington Caledon Socy</i>		12a. JSA. OCCUPATION (Kind of work done during most of working life even if retired) <i>House wife</i>	12b KIND OF BUSINESS OR INDSTRY <i>Own house</i>				
13a. USUAL RESIDENCE (Where deceased lived if institution Res date before admission) STATE <i>Maryland</i>	13c CITY OR TOWN <i>Montgomery</i>	13d INSIDE CITY LIMIT <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>3213 VERONA PLACE</i>					
14 FATHER'S NAME First <i>Coustar</i>	Middle <i>Bergman</i>	15 MOTHER'S MAIDEN NAME First <i>Mary</i>	Middle <i>Olsen</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>578-30-8705</i>	17 INFORMANT <i>Son</i>	Address <i>Mr. Jay Glenn 3213 Verona Pl., Wheaton, Md.</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Anterior sclerotic heart disease</i>						
41a Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs.</i>						
(b)		DUE TO, OR AS A CONSEQUENCE OF <i>Anterior sclerosis</i>						
(c)		DUE TO, OR AS A CONSEQUENCE OF <i>Anterior sclerosis</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>42.</i>								
19a DATE OF OPERATION <i>4/21</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING (If either, notify medical examiner) <input type="checkbox"/> Cause of death <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work	21b TIME OF INJURY Hour A.M. Month Day Year <i>P.M. 19</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>At home farm, street, factory, office building, etc.</i>						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work	21e PLACE OF INJURY <i>At home farm, street, factory, office building, etc.</i>	21f LOCATION Street or RFD No <i>~</i>	City or Town <i>~</i>		County <i>~</i>		State <i>~</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>1963</i> , 19, to <i>Oct. 24, 1968</i> , that (I) (we) last saw the deceased alive on <i>9/26/68</i> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <i>A. W. Smith M.D.</i>	DEGREE <input checked="" type="checkbox"/> MED. ATTENDING PHYS <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>10/24/68</i>						
22d PHYSICIAN'S NAME (Type) <i>A. W. SMITH</i>	22e ADDRESS <i>13018 GEORGIA AVE Wheaton, MD</i>							
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE <i>Oct. 26, 1968</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Groes Ridge Cemetery</i>	23d LOCATION (City or Town) <i>Keosha</i>	(County) <i>Wicomico Co.</i>		(State) <i>MD</i>		
24 FUNERAL DIRECTOR <i>Glen Carter</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						
VR. A15 141 45M - 1/69	DATE <i>OCT 28 1968</i>							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14630

14622

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within 72 hours after death.

1 DECEASED-NAME (Type or print)		First Alma	Middle M.	Last GOODE	2a DATE OF DEATH Month October	Day 9	Year 68	2b HOUR 630p M	
3. SEX Female		4 RACE Negro		5. DATE OF BIRTH June 18, 1915		6. AGE (In years last birthday) 53		IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 1501 Crittenden St., N.W.			
14. FATHER'S NAME First Adolphus		Middle Wiggins	Last	15. MOTHER'S MAIDEN NAME First Lillian		Middle Drake	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Washington		Address Benjamin C. Coode, 2116 F St., N.W. Apt. 108		D. C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TRANSITIONAL CELL CARCINOMA OF BLADDER WITH WIDE DUE TO, OR AS A CONSEQUENCE OF SPREAD METASTASIS.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>18.</i>									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 9, 1968 , to Oct. 9, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 9, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE <i>Donald J. Jarzynski</i>		DEGREE <i>Attending Phys</i>	ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED Oct. 10, 1968			
22d. PHYSICIAN'S NAME (Type) DONALD J. JARZYNSKI		22e. ADDRESS Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL <input type="checkbox"/>		23b. DATE Oct 14-68		23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Church Cemetery		23d. LOCATION (City or Town) Washington, D.C.		(County)	(State)
24. FUNERAL DIRECTOR Spangler Funeral Home		<i>William Spangler</i>		25a. REC'D. BY REGISTRAR OCT 14 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
524 8th St., N.E., Washington, D.C.									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14623

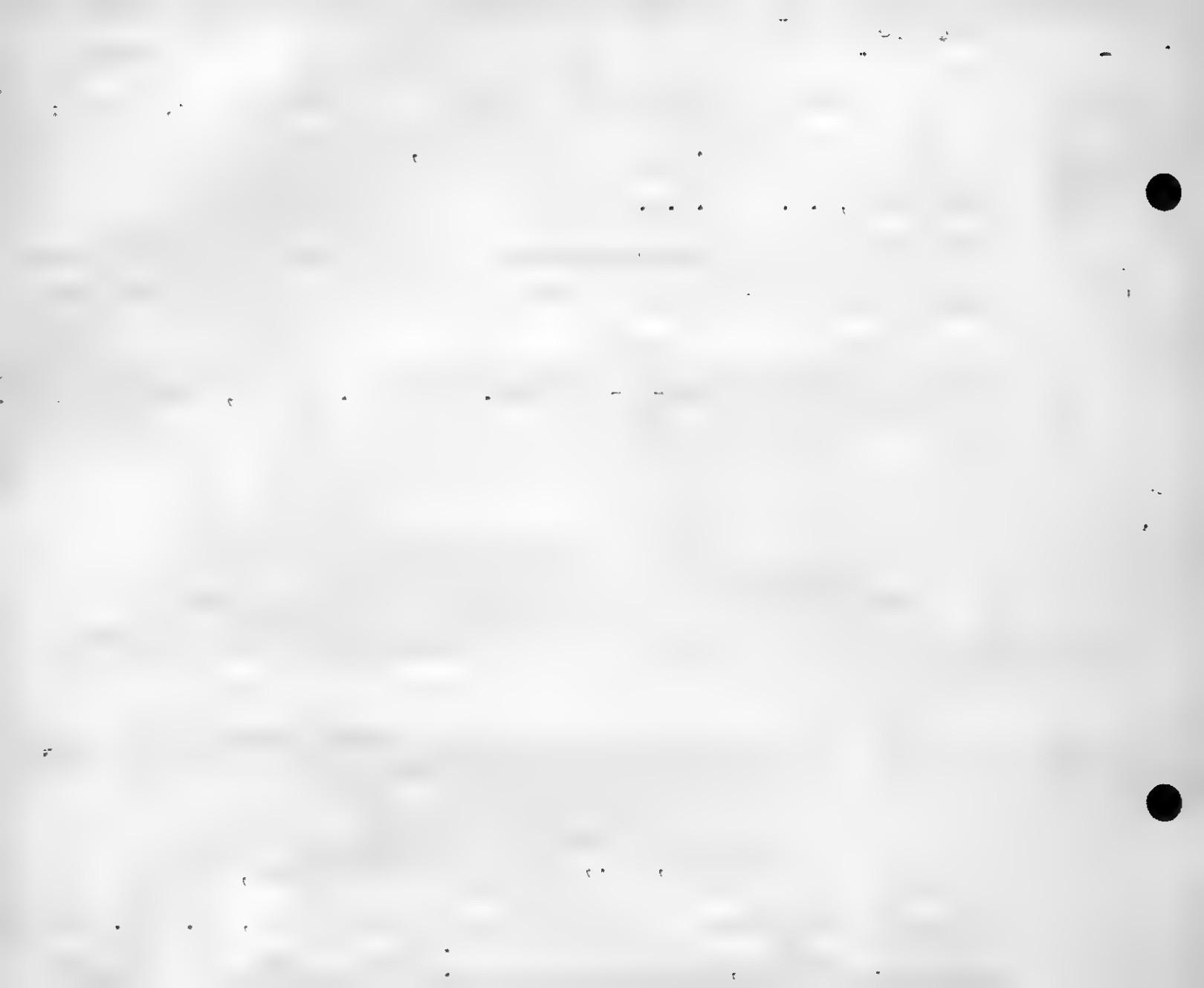
14631

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be returned by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First MIRIAM	Middle MORGAN	Last GORDON	2a DATE OF DEATH Month October	2b HOUR P Dy 24, 1968
3 SEX Female	4 RACE Cauc.	5. DATE OF BIRTH June 18, 1878		6 AGE (In years last birthday) 90	F UNDER 1 YEAR MONTHS YRS.
7a BIRTHPLACE (State or foreign country) Washington, D.C.	7b CIT.ZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	10a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	10b USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker
10c CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker	12b KIND OF BUSINESS OR IND. STRY Own Home		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Kensington	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 10106 Thornwood Road	
14. FATHER'S NAME First JOHN	Middle MORGAN	Last	15 MOTHER'S MAIDEN NAME First MARY	Middle FRANCES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 578-09-8746	17 INFORMANT Mrs. Miriam G. Griest, Kensington, Md	10106 old Thornwood Road, Mrs. Miriam G. Griest, Kensington, Md		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Generalized arterosclerosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days		
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arterosclerosis					
DUE TO, OR AS A CONSEQUENCE OF (c) 					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized osteoporosis					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 68 , to Oct 24 68 , that (I) () last saw the deceased alive on Sept 24 68 19 68 and that in (my) () x apianian death occurred on the date and hour and from the causes stated above, (I) () () did () did not view the body after death.					
22b. SIGNATURE Herbert Martyn Jr., MD	DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 25 Oct 68	
22d. PHYSICIAN'S NAME (Type) HERBERT MARTYN, JR., MD	22e. ADDRESS 4740 Chevy Chase Drive Chevy Chase, Maryland				
23a BURIAL CREMATION. REMOVAL (Specify) Entombment	23b DATE 10/28/68	23c NAME OF CEMETERY OR CREMATORIUM Cedar Hill Mausoleum	23d. LOCATION (City or Town) Suitland, Pr. Geo. Maryland	(County) 	(State)
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland	25a. ADDRESS 7557 Wisconsin Ave.	25b. DATE NOV 4 1968	25c. REGISTRAR'S SIGNATURE Charles Judge	25d. REC'D BY REGISTRAR 	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14626

14632

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR AM / PM	
Ethel D. GRANT					10-25-68	7 A.M.	
3. SEX FEMALE		4. RACE white	5. DATE OF BIRTH 2-23-88		6. AGE (in years last birthday) 88 yrs		
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 6620 Hillandale Rd.
14. FATHER'S NAME Joseph Wm. Dawson		15. MOTHER'S MAIDEN NAME Dell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 220-26-6877		17. INFORMANT (son) Ben. J. GRANT - 7000 Greenway Pkwy		Address Spence Bethesda, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic + cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Car cavitosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Car cavitosis</u> (c) <u>carcinoia of sigmoid</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Unknown							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>68</u> , to <u>Oct</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>24 Oct</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Herbert Martyn MD		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 25 Oct 68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Herbert Martyn Jr 4740 Chevy Chase Dr.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-26-1968	23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) Dothan, Alabama	(County)	(State)
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., N.W., Wash., D.C., 20016		ADDRESS 3130 Wisc. Ave.		25a. REC'D BY REGISTRAR DATE OCT 28 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14633

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>Betty</i>	Middle <i>ANN</i>	Last <i>Greenwood</i>	2a. DATE OF DEATH Month <i>Oct</i>	Day <i>17</i>	2b. HOUR <i>8 AM</i>	
3. SEX <i>FEMALE</i>	4. RACE <i>WHITE</i>	S. DATE OF BIRTH <i>5/1/26</i>	6. AGE (In years last birthday) <i>42 yrs.</i>	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>			
7a. BIRTHPLACE (State or foreign country) <i>WASHINGTON, DC</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>MONTGOMERY</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>			
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>SUBURBAN</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY / M.T.P. <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>12103 Posttree Drive</i>		
14. FATHER'S NAME First <i>Theodore</i>	Middle <i>VOLLTEIN</i>	Last <i>IND.</i>	15. MOTHER'S MAIDEN NAME First <i>Austin Greenwood - HUSBAND - SAME</i>	Middle <i>BEAN</i>	Last <i>22 lbs</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO (If yes give name or dates of service) <i>219-22-4586</i>	17. INFORMANT <i>Austin Greenwood - HUSBAND - SAME</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>22 lbs</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 4300 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ruptured aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART 1(a) <i>Hypertension (one year duration)</i>							
19a. DATE OF OPERATION <i>1966</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <i>None</i>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>None</i>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) <i>None</i>	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>14 Oct 1966</i> to <i>17 Oct 1966</i> , that (I) (we) last saw the deceased alive on <i>14 Oct 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>Paul T. Noone MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>12 Oct 68</i>				
22d. PHYSICIAN'S NAME (Type) <i>PAUL T. NOONE</i>	22e. ADDRESS <i>5201 Randolph Road Rockville, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10-21-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>	23d. LOCATION (City or Town) <i>Rockville, Maryland</i>	(County) <i>Montgomery</i>	(State) <i>Maryland</i>		
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	25a. REC'D. BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14628

CERTIFICATE OF DEATH

14634

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~exhibited~~ within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First <i>James</i>	Middle <i>A.</i>	Last <i>Guzzo</i>	2a DATE OF DEATH Month <i>Oct.</i> Day <i>23</i> Year <i>1968</i>	2b HOUR <i>5 P.M.</i>
3. SEX <i>Male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>11/10/20</i>		6. AGE (in years last birthday) MONTHS <i>47</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>West Palm Beach</i>	11 NAME OF HOSPITAL, OR INSTITUTION (if not in hospital 9, ve street address) <i>Jubilee Hospital</i>	12a USLAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Suburban Contractor Building</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Building</i>	
13a. USLAL RESIDENCE (Where deceased admission) STATE <i>Md.</i>	13c. CITY OR TOWN <i>Montgomery</i>	13d. INS. DE CITY LIMITS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>6515 - 8th Ave. N.E. Montgomery, Md.</i>		
14. FATHER'S NAME First <i>Joseph</i>	Middle <i>B. Gulli</i>	15. MOTHER'S MAIDEN NAME First <i>Gertrude Milford</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown <i>Yes</i>	16b. SOCIAL SECURITY NO <i>579-12-2366</i>	17 INFORMANT <i>Marguerite Gulli As above.</i>	Address <i>Same</i>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
4107 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
4201 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJRY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJRY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJRY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>1955</i> , 19, to <i>10/25</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Oct 8</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <i>Thomas E. Curtin M.D.</i>					
22d. PHYSICIAN'S NAME (Type)	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22e. DATE SIGNED <i>10/25/68</i>	
23a. BURIAL, CREMATON, REMOVAL (Specify) <i>Cremation</i>	23b. DATE <i>10/28/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery Silver Spring, Md.</i>	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <i>Home Funeral</i>	ADDRESS <i>Mr. George</i>	25a. REC'D. BY REGISTRAR <i>DCT 31 1968</i>	25b. REG STRK'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14627

14635

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First ALEXINA	Middle K.	Lost GUSEK	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month Oct.	Day 24	Year 1968	2b HOUR UNK M			
3 SEX female	4 RACE white	5 DATE OF BIRTH June 4, 1911	6 AGE (in years last birthday) 57 yrs	7 IF UNDER 1 YEAR MONTHS 5	8 IF UNDER 24 HRS DAYS 0	9 HOURS 0	M.N. 0	2c DATE PRONOUNCED DEAD Month October	Day 27	Year 1968	2d HOUR 2 P.M.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9 WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4743 Bradley Boulevard				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before Maryland)		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER 4743 Bradley Blvd. Apt. 307						
14. FATHER'S NAME James		First Keay	Middle Sr.	Lost Helen	15. MOTHER'S MAIDEN NAME Mann							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO XXXXXX		17. INFORMANT Ridgewood Dr.		ADDRESS Russell, Mass.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1 DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) Fatty Alteration of Liver												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost. (b)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Werner U. Spitz</i>		M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/28/68				
23a. BURIAL, CREMATON, REMOVAL (Specify) Removal		23b. DATE 10/29/68		23c. NAME OF CEMETERY OR CREMATORIAL Pine Hill Cemetery		23d. LOCATION (City or Town) Westfield, Hampden, Mass.		(County)		(State)		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. ADDRESS 7557 Wisconsin Ave.		25b. REC'D BY REGISTRAR NOV 4 1968		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14623

14636

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

Attended with medical Examiner John Beck MD - Michael R. S. - Michael R. S.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 11:58 P.M.	
MYRON				E.	GUSTAFSON	OCTOBER 12, 1968			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>June 23, 1910</i>		6. AGE (In years last birthday) <i>58</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Nebraska</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Ranger-oilburner serv. Kable & Det</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Kable & Det</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13c. CITY OR TOWN <i>Montgomery Sil. Spr.</i>		13d. INSIDE CITY LIMITS <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>		13e. STREET AND NUMBER <i>701 McNeil Road</i>			
14. FATHER'S NAME <i>Theodore M.</i>		15. MOTHER'S MAIDEN NAME <i>Gustafson</i>		16. SOCIAL SECURITY NO. <i>577-10-0062</i>		17. INFORMANT <i>Avis Gustafson 701 McNeil Road Sil. Spr. Md.</i>		Address	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown <i>No</i>		16b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock + pulmonary edema</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial infarction</i>		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease</i>		10 yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (1) (this hospital) attended the deceased from <i>Aug. 1960</i> , to <i>Oct 12, 1968</i> , that (1) (we) lost saw the deceased alive on <i>Oct 12, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>James R. Coleman MD</i>		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <i>10/12/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>JAMES R. COLEMAN</i>		22e. ADDRESS <i>9241 COLUMBIA BLVD. SILVER SPRING, MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>10-16-1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Park Lawn Cemetery</i>		23d. LOCATION (City or Town) <i>Rockville</i>		(County) (State) <i>Montgomery, Md.</i>	
24. FUNERAL DIRECTOR <i>C. Glen Carter</i>		ADDRESS <i>Sil. Spr. Md.</i>		25a. RECD BY REGISTRAR <i>Warren E. Pumphrey, Inc.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15 (4) 30M REV. 1/68		DATE <i>OCT 21 1968</i>							



FOR STATE
HEALTH DEPT.

14629

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14637

1. DECEASED NAME (Type or Print)	First JAMES Middle HARRINGTON Last HAGEN	20 DATE KNOWN OF ESTI- DEATH MATED	Month Oct	Day 11	Year 1968	2b HOUR 2 P.M.
3 SEX MALE	4 RACE W.	5 DATE OF BIRTH Sept 18, 1945	6 AGE (in years lost birthday) 23 yrs	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS. DAYS	9 IF UNDER 24 HRS. HOURS
7a BIRTHPLACE (State or foreign country) Washington DC	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery	2c DATE PRONOUNCED DEAD Month Oct	Day 11	Year 1968
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5215 Belvoir Dr	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland	13b CITY OR TOWN Montgomery	13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d STREET AND NUMBER 5215 Belvoir Dr.			
14. FATHER'S NAME First Stanley Middle Hagen Lost	15. MOTHER'S MAIDEN NAME First Pauleen Middle Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) YES N-12-6470 12-17-66	16b SOCIAL SECURITY NO -	17. INFORMANT MRS. PAULEEN M. HAGEN, MOTHER, SAME AS #13	ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anoxia 8567 DUE TO, OR AS A CONSEQUENCE OF Overdose of narcotics				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 874.0						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 2 ? PM Oct 11 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) Injected narcotics by vein self inflicted		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No City or Town 5215 Belvoir Dr. Bethesda Montg. Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE John S. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Oct 13. 1968		
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE 10-17-1968		23c. NAME OF CEMETERY OR CREMATORIAL Massanutton Cemetery		
Removal-Burial				23d. LOCATION (City or Town) (County) (State) Woodstock, Virginia		
24. FUNERAL DIRECTOR Joseph Gowler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS		25a. REC'D BY REG STRR DGT 21 1968		
				25b. REGISTRAR'S SIGNATURE Quinton George		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

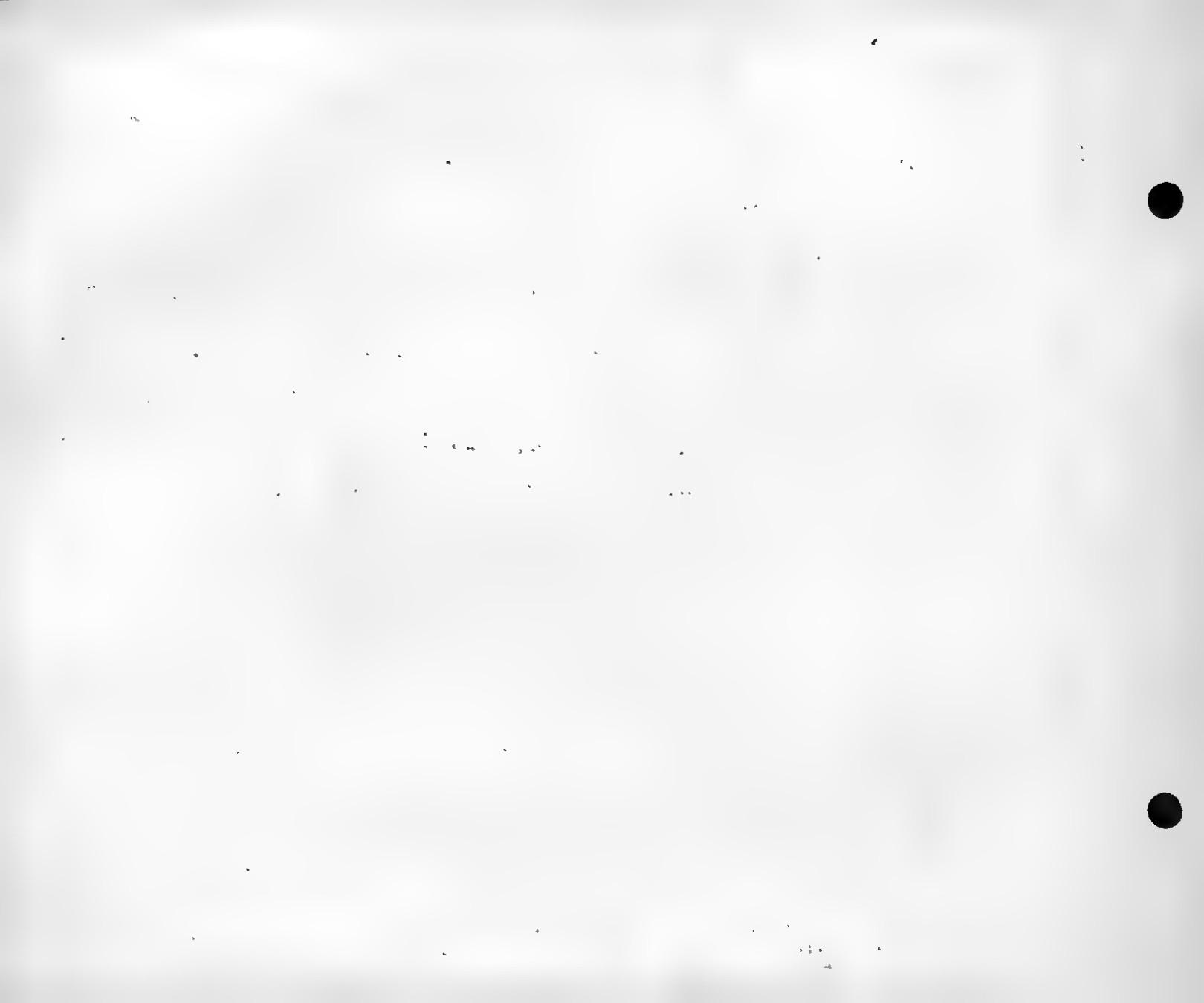
14638

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 12 P.M.	
<u>MISS ELLA E. HALL</u>				<u>HALL</u>	<u>10</u>	<u>30</u>	<u>68</u>		
3. SEX		4. RACE		S. DATE OF BIRTH	6. AGE (in years last birthday)				
<u>Female</u>		<u>White</u>		<u>10-31-1883</u>	<u>78</u> YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
<u>P.A.</u>		<u>U.S.A.</u>				<u>Montgomery</u>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
<u>Silver Spring</u>		<u>Holy Cross Hospital</u>			<u>Waitress</u>		<u>Food</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
<u>Md.</u>		<u>Montgomery</u>		<u>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>		<u>804 Arrington Drive</u>		<u>Sil. Spr. Md.</u>	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
<u>Thomas</u>		<u>?</u>		<u>Hall</u>	<u>Catherine</u>	<u>M.</u>	<u>?</u>	<u>Cal'ny</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
<u>No</u>		<u>137-18-1686</u>		<u>Catherine Hall</u>		<u>804 Arrington Dr. S.S., Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arterosclerotic Cardiovascular Disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>with Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4129 <u>Bronchitis pneumonia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					<u>YES <input type="checkbox"/> NO <input type="checkbox"/></u>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 26, 1968</u> , to <u>Oct 30, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 29, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Bernard A. Fitzgerald</u>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>10-30-68</u>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>217 Union Bluff, Silver Springs, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>11-7-1968</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Sacred Heart Cemetery</u>		23d. LOCATION (City or Town) <u>Newark, N.J., Jersey</u>		(County)	(State)
24. FUNERAL DIRECTOR <u>See Will</u>		ADDRESS <u>At c/o E. Murphy, Inc. 81134 Georgia Ave.</u>		25a. RECD BY REGISTRAR <u>Sil. Spr. Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14639

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First ADA	Middle GAY	Last HARMON	2d. DATE OF DEATH Month October Day 22 , Year 1968	2b. HOUR 1:00
3. SEX Female	4 RACE Cauc.	5. DATE OF BIRTH Feb. 7, 1879		6 AGE (In years last birthday) 89	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4523 Avondale Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4523 Avondale Street	12b. KIND OF BUSINESS OR INDUSTRY
14. FATHER'S NAME First Arthur Webster Paxton	Middle 	Last 	15. MOTHER'S MAIDEN NAME First Augusta Rogers Snavely	Middle 	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Years, or unknown) No	16b. SOCIAL SECURITY NO. Unknown	17. INFORMANT Daughter Lois H. Boatwright	Address Same as Item 13	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 DAY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) INTESTINAL OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF 5609 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 5705G GENERALIZED ARTERIO SCLEROSIS					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERAT. ON WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED With <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from JUNE, 1965, to OCT, 1968 , that (I) (we) last saw the deceased alive on OCT, 21, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Leo I. Donovan</i>	DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 10-22-68
22d. PHYSICIAN'S NAME (Type) LEO I. DONOVAN	22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-25-68	23c. NAME OF CEMETERY OR CREMATORIUM Zion Cemetery	23d. LOCAT ON (City or Town) Nebo, Virginia	(County)	(State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland	ADDRESS 	25a. REC'D BY REGISTRAR DATE OCT 24 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

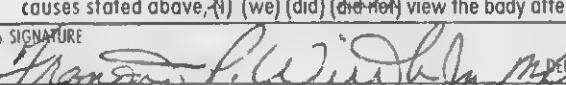


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed ~~within~~ 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1 DECEASED-NAME (Type or print)			First Leonard	Middle Boyd	Last Harper	2a. DATE OF DEATH Month October		Day 31	Year 1968	2b. HOUR 9:50 M			
3. SEX <input checked="" type="checkbox"/> Male		4 RACE White		5. DATE OF BIRTH August 5, 1936		6. AGE (in years last birthday) 32		IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery							
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.) Salesclerk			12b. KIND OF BUSINESS OR INDSTRY Fuel & Feed				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13c. CITY OR TOWN Prince Georges			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 9729 Wichita Ave					
14. FATHER'S NAME First Leonard			Middle W.			15 MOTHER'S MAIDEN NAME Harper			First Dellie			Middle I.	Last Bennett
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 219-34-8740			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Intracerebral Hemorrhage										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) Increased Intracranial pressure									days	
			DUE TO, OR AS A CONSEQUENCE OF (c) Glioblastoma Multiforme									6 Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION 1955		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> Cause of death (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFF CE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 29, 1968, to October 31, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 31, 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death													
22b. SIGNATURE 					22c. DATE SIGNED 10/31/68								
22d. PHYSICIAN'S NAME (Type)		Fremont P. Wirth, Jr., MD.			22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 2, 1968		23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		23d. LOCATION (City or Town) Colmar Manor Pro Geo, Md.		(County)		(State)			
24 FUNERAL DIRECTOR		ADDRESS F. Gasch's Sons Hyattsville, Md.			25a. REC'D. BY REGISTRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE 						



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
14633			14641									
I. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN <input type="checkbox"/> Month Day Year			2b. HOUR			
Helen. Virginia				2.	Harris.	Oct 3 1968 3:00 P.M.						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years at birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		
Fe. w		9/10/1905		63 yrs						Oct 3 1968 6:30 A.M.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Baltimore			U.S.A.						Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore			Suburban			Housewife						
13a. JURAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER			
Maryland			Montgomery			Rockville			9500 Eldwick Way			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Robert E. Lee O'Neale						Margaret Collins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT			18. ADDRESS			
No			None			Brother Wm. M. O'Neale			Wilmett Rd. Bethesda, Md.			
PART I. DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) Anoxia												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Carbon Monoxide & Smoke Inhalation - 1/2 hr.												
DUE TO, OR AS A CONSEQUENCE OF												
(c) House fire												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?						
19c.						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
CAUSE OF DEATH			3 PM 10/3 1968			Safa caught on fire from cigarette						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State						
			Home			9500 Eldwick Way Rockville Montgomery Md						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			JOHN G. BALL			CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)			JOHN G. BALL			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)			JOHN G. BALL			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town) (County) (State)			
Burial			10-7-68			Potomac Meth. Ch. Gem.			Potomac, Maryland			
24. FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY, Bethesda, Maryland						OCT 9 1968			Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14642

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. In any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>MARY</i>	Middle <i>Ditto</i>	Last <i>HART</i>	2a. DATE OF DEATH Month <i>10</i>	Day <i>30</i>	Year <i>68</i>	2b HOUR <i>9 1/2 AM</i>
3. SEX <i>FEMALE</i>	RACE <i>white</i>	5. DATE OF BIRTH <i>10-9-16</i>		6. AGE (In years last birthday) <i>52 yrs</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>NEBRASKA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>MONTGOMERY County, Md.</i>				
10. CITY OR TOWN OF DEATH <i>SILVER SPRING, Md.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>No No sales</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Office</i>		
13c. USUAL RESIDENCE (Where deceased lived, if institutionalized before admission) STATE <i>Neb.</i>	13d. CITY OR TOWN <i>Omaha</i>	13e. INSIDE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13f. STREET AND NUMBER <i>121-S. 53rd St.</i>				
14. FATHER'S NAME First <i>No as</i>	Middle <i>C.</i>	Last <i>Ditto</i>	15. MOTHER'S MAIDEN NAME First <i>Madeleine</i>	Middle <i>(husband)</i>	Last <i>O'Connor</i>	Address <i>Oraha, Nebraska</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>508-03-5670</i>	17. INFORMANT <i>Joseph M. Hart</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Cysticercosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug. 1968</i> , to <i>Oct. 1968</i> , that (I) (we) last saw the deceased alive on <i>Aug. 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>M. Shapiro</i>	DEGREE <i>MD.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/30/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Morton Shapiro</i>	22e. ADDRESS <i>8107 Eastern Avenue, Sil. Spr. Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>11-3-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Calvary Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Oraha, Nebraska</i>				
24. FUNERAL DIRECTOR <i>Carter Coffin Carter</i>	ADDRESS <i>Sil. Spr. Md.</i>	25a. REC'D. BY REGISTRAR DATE <i>NOV 7 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14635

CERTIFICATE OF DEATH

14643

1. PLACE OF DEATH

a. COUNTY
MONTGOMERY

MARYLAND

b. CITY OR TOWN (If outside corporate limits
write RURAL and give nearest town)

CHEVY CHASE

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
6412 BROOKSIDE DRIVE3. NAME OF
DECEASED
(Type or print)First
ROBERTMiddle
WITTLast
HARVEY5. SEX
MALE6. COLOR OR RACE
WHITE7. MARRIED NEVER MARRIED
WIDOWED DIVORCED 8. DATE OF BIRTH
AUGUST 27, 19129. AGE (In years
at birthday)
56 yrs.10. IF UNDER 1 YEAR
Months Days Hours Min.4. DATE
OF
DEATH
OCTOBER 1 196810a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)10b. KIND OF BUSINESS OR INDUSTRY
COAL11. BIRTHPLACE (County & State or foreign country)
CHARLESTON, WEST VA.12. CITIZEN OF WHAT COUNTRY?
U. S. A.13. FATHER'S NAME
RALPH WIRT HARVEY14. MOTHER'S MAIDEN NAME
LAURA E. ELLIS15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, No, or Unknown) WW II KOREA

16. SOCIAL SECURITY NO.

579-16-9832

17. INFORMANT

MRS. CRIXY S. HARVEY SAME AS 2d

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

HEPATIC COMA

DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.
(b)

DUE TO

(c)

POST-NECROTIC CIRRHOSIS

INTERVAL BETWEEN
ONSET AND DEATH
5 DAYS

6 yrs

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY Home, farm,
factory, street, office bldg., etc.

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 16 FEB 1968 to 1 OCT 1968, that (I) (we) last saw the deceased alive on 30 SEPT 1968, and that death occurred at 8:10 AM, from the causes and on the date stated above

22a. SIGNATURE

Richard M. Huffman,

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
1 OCT 196822c. PHYSICIAN'S
NAME (Type)
Richard M. Huffman, M.D.22d. ADDRESS
2001 Eye St., N.W., Washington, D.C.23a. BURIAL/CREMATION
BOARD23b. DATE THEREOF
REMOVAL (Specify)
Oct. 1, 6823c. NAME OF CEMETERY OR CREMATORIAL
SCHOOL OF MEDICINE

23d. LOCATION (City, town or county)

(State)

WASHINGTON, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE

Joseph Gowler's Sons, Inc. 5130 Wisc. Ave. N.W.
Washington, D.C.

ADDRESS

25a. REC'D BY REGISTRAR
DATE

OCT

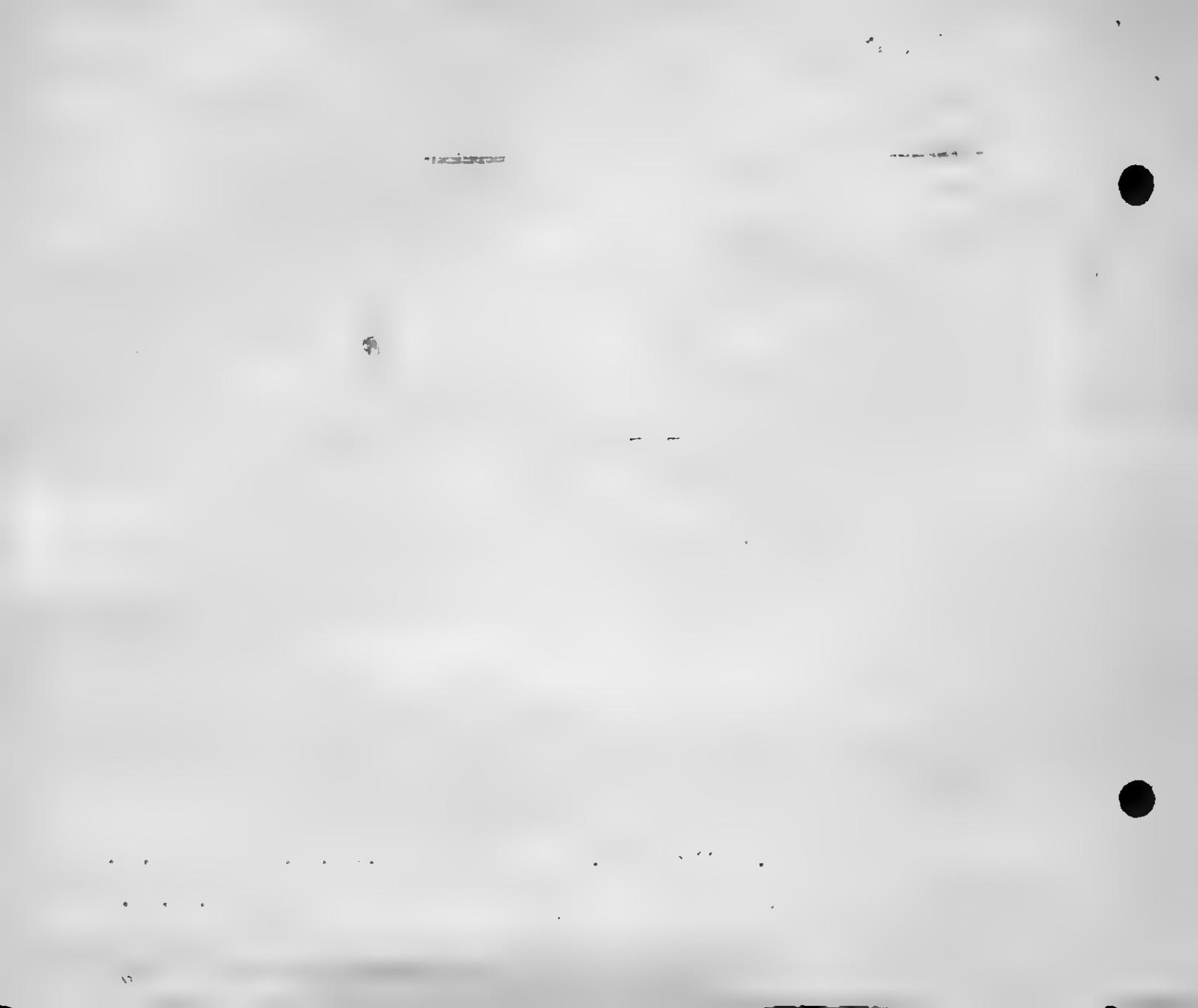
7 1968

25b. REGISTRAR'S SIGNATURE

j Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14644

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

14636		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH						14644	
1. DECEASED NAME (Type or print)		First BLANCHE	Middle B.	Last HAUSLER	2a. DATE OF DEATH 10 Month 26 Day 1968		2b. HOUR 100p.m.		
3. SEX Female		4 RACE White		5. DATE OF BIRTH Aug 1 - 1888		6. AGE (in years last birthday) 80 yrs		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		12b. KIND OF BUSINESS OR INDUSTRY Md. Govt.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cottage Hill Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Clerk		13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5101 Ridgefield Road	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5101 Ridgefield Road	
14. FATHER'S NAME Albert		15. MOTHER'S MAIDEN NAME Lauck		16b. SOCIAL SECURITY NO. 577-46-7805		17. INFORMANT Joseph Hauser, Husband, 5101 Ridgefield Rd		Address Regan	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour							
18c. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		18d. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		18e. DUE TO, OR AS A CONSEQUENCE OF (b)		18f. DUE TO, OR AS A CONSEQUENCE OF (c)		18g. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus.									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10/26/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harold J. Passes MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/26/68.					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 8612 Hartsdale Ave Bethesda Md.							
23a. BURIAL, CREMATION, BURIAL (Specify) Burial		23b. DATE 10-29-1968		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery		23d. LOCATION (City or Town) Silver Spring		(County) Montgomery Co.	
24. FUNERAL DIRECTOR Joseph Hawler's Sons, Inc., 3130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			
DATE OCT 30 1968									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14645

14637

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Lelia Elizabeth	Last Heller	2a. DATE OF DEATH Month Oct.	Day 13	Year 1968	2b. HOUR Hour 2:30 P.M.										
3. SEX FEMALE		4. RACE WHITE	S. DATE OF BIRTH 9/29/94	6 AGE (In years last birthday) 74 YRS		IF UNDER 1 YEAR MONTHS 0		IF OVER 24 HRS. HOURS 0									
7a. BIRTHPLACE (State or foreign country) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Silver Spring		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission STATE Maryland , COUNTY Montgomery)		13c. CITY OR TOWN Potomac	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8815 Tuckerman Lane													
14. FATHER'S NAME First (Unknown)		Middle Garbo	Last Ellie	15. MOTHER'S Maiden Name First Ellie M. Ellmore		Middle Jane	Last James A. Heller	Address Same as above									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No.												16b. SOCIAL SECURITY NO. Xxx-xxx-xxxx		17. INFORMANT Rev. James A. Heller		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) metastatic carcinoma of liver & lungs																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												(b)					
DUE TO, OR AS A CONSEQUENCE OF (b)												DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 6 x arteriosclerotic heart disease & cong. heart																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 7801 FOXFOLK AVE.		City or Town Bethesda, Md.		County Montgomery		State MD							
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1968 , to 10-12, 1968 , that (I) (we) last saw the deceased alive on 10-12 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE John M. Wynn		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/12/68	
22d. PHYSICIAN'S NAME (Type) John M. Wynn		22e. ADDRESS 7801 FOXFOLK AVE., Bethesda, Md.															
23a. BURIAL, CREMATION, REMOVAL (Check)		23b. DATE 10-17-68		23c. NAME OF CEMETERY OR CREMATORIAL High Hill Cemetery		23d. LOCATION (City or Town) Lake, Mississippi		(County) Mississippi		(State)							
24. FUNERAL DIRECTOR'S NAME (Type) Robert A. Humphrey		ADDRESS 53 Wisconsin St., Bldg. 2, Milwaukee, Wis.		25a. REC'D BY REGISTRAR DATE OCT 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14638

14646

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 months after death.

1 DECEASED-NAME (Type or print)	First <i>Anna</i>	Middle	Last <i>Heltzman</i>	2a. DATE OF DEATH Month <i>Oct</i>	Day <i>7</i>	Year <i>1968</i>	2b. HOUR <i>5:40 AM</i>
3. SEX <i>Female</i>	4. RACE <i>white</i>	S. DATE OF BIRTH <i>7/3/04</i>	6. AGE (In years last birthday) <i>64 yrs.</i>	IF UNDER 1 YEAR MONTHS <i>0</i>			IF UNDER 24 HRS. HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Ronan</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>MONTGOMERY Co.</i>				
10. CITY OR TOWN OF DEATH <i>SILVER SPRING</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>	12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Md</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>	13c. CITY OR TOWN <i>SILVER SPR.</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>1427 CHURCH DR.</i>				
14. FATHER'S NAME First <i>SAMUEL</i>	Middle <i>WARSAW</i>	15. MOTHER'S MAIDEN NAME First <i>CHARA</i>	Middle <i>BAUMAN</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mary E. Heltzman</i>	Address <i>JAME A. S. 13</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pneumonia, right lower lobe</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>			
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost <i>490x</i>							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cerebral thrombosis, old & Rheumatoid arthritis 3) Malnutrition and dehydration</i>							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 27, 1968</i> , to <i>Oct 7, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 6, 1968</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>George S. Kenton, M.D.</i>				DEGREE <input type="checkbox"/> MED. ATTENDING PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/7/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>George S. Kenton, M. D.</i>				22e. ADDRESS <i>10829 Georgia Avenue Wheaton, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>D.C. LODGE CEM</i>	23b. DATE <i>10-9-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>D.C. LODGE CEM</i>	23d. LOCATION (City or Town) (County) <i>WASHINGTON DC</i>				
24. FUNERAL DIRECTOR <i>George S. Kenton, M. D.</i>	ADDRESS <i>4217 Georgia Avenue N.W.</i>	25a. RECEIVED BY REGISTRAR DATE <i>OCT 9 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

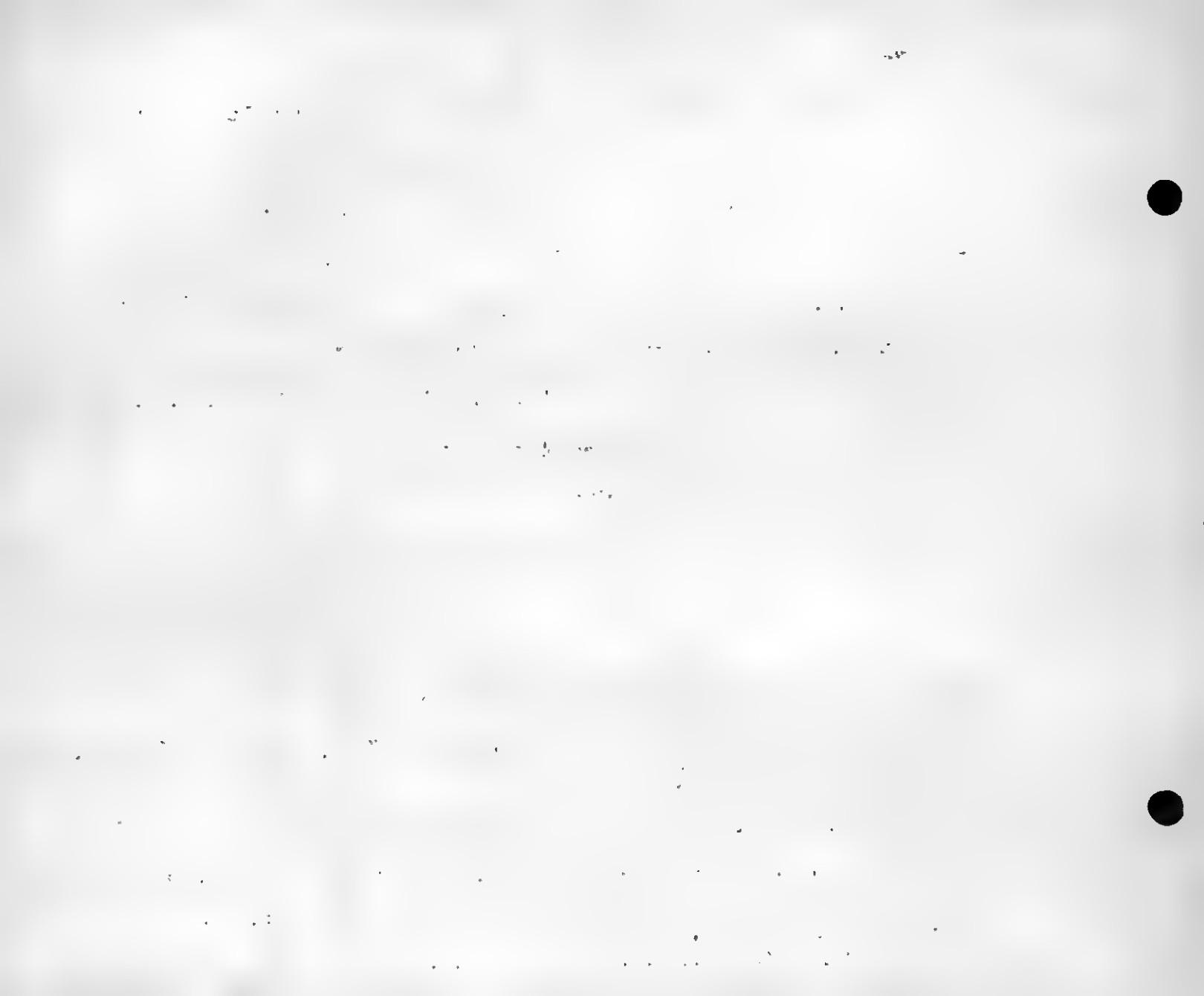
14639

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14647

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	Month	Doy	Year	2b. HOUR		
Dorothy Frances HENDERSON						October 21 1968			4:25 P.M.			
3. SEX	4. RACE		5. DATE OF BIRTH			6 AGE (in years last birthday)			IF UNDER 24 HRS			
Female	Cauc		17 August 1916			52			MONTHS	YEARS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH						
		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery						
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPAT On (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		Naval Hospital			Housewife							
13a. USUA. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Washington, D.C.				Washington		YES <input type="checkbox"/> NO <input type="checkbox"/>		4707 Reservoir Road				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Lost			
George HENDERSON					Bessie MASON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		4707 Reservoir Road, Address						
No				Douglas HENDERSON		Washington, D. C.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY:												
1970 IMMEDIATE CAUSE (a) Bleeding esophageal varices												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of liver												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 7 October 1968 to 21 October 1968, that <input type="checkbox"/> (we) last saw the deceased alive on 21 October 1968, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.												
22b. SIGNATURE <i>J. McCreule</i>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 23 October 1968								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Naval Hospital, Bethesda, Maryland										
T. M. SCHENK, M.D.												
23a. BURIAL, CREMATION, REMOVAL, ETC. Cremation		23b. DATE Oct. 23, 1968		23c. NAME OF CEMETERY OR CREMATORIY Cedar Hill Crematory		23d. LOCATION (City or Town) Suitland, Md.		(County)		(State)		
24. FUNERAL DIRECTOR De Vol Funeral Home, 2222 Wisconsin Ave., N.W. Washington, D.C.		ADDRESS		25a. RECD BY REGISTRAR DATE OCT 25 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14640

14648

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First John	Middle Richard	Last Henderson	2a. DATE OF DEATH Month Oct. 30, 1968	Day Year 1968	2b. HOUR
3. SEX		4 RACE Male White		S. DATE OF BIRTH Oct. 27, 1877	6. AGE (in years last birthday) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? Nebraska USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		Md.
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Salesman		12b. KIND OF BUSINESS OR INDUSTRY Auto	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Calif.		13b. COUNTY Pomona		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1329 W. Mission Blvd.		
14. FATHER'S NAME Joseph		Middle Henderson		15. MOTHER'S MAIDEN NAME Emily	Middle		Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 547-10-8239A		17. INFORMANT Mrs. Clara B. Henderson		Address 1329 W. Mission Blvd. Pomona, California	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 u.s. 1							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>ARTERIOSCLEROTIC CEREBROVASC DIS.</u> Years lost. 35 IX							
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>PNEUMONIA</u>							
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <u>10/20, 1968</u> , to <u>10/30, 1968</u> , that (I) (we) last saw the deceased alive on <u>10/30, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Richard H. Pollen</u>		MD DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>10/30/68</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>10400 Connecticut Ave, Kensington, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Oct. 31, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		23d. LOCATION (City or Town) Washington, D.C.	
24. FUNERAL DIRECTOR <u>Francis J. Collins</u>		ADDRESS 500 University Blvd. W. Silver Spring, Md.		25a. REC'D BY REGISTRAR NOV 1 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

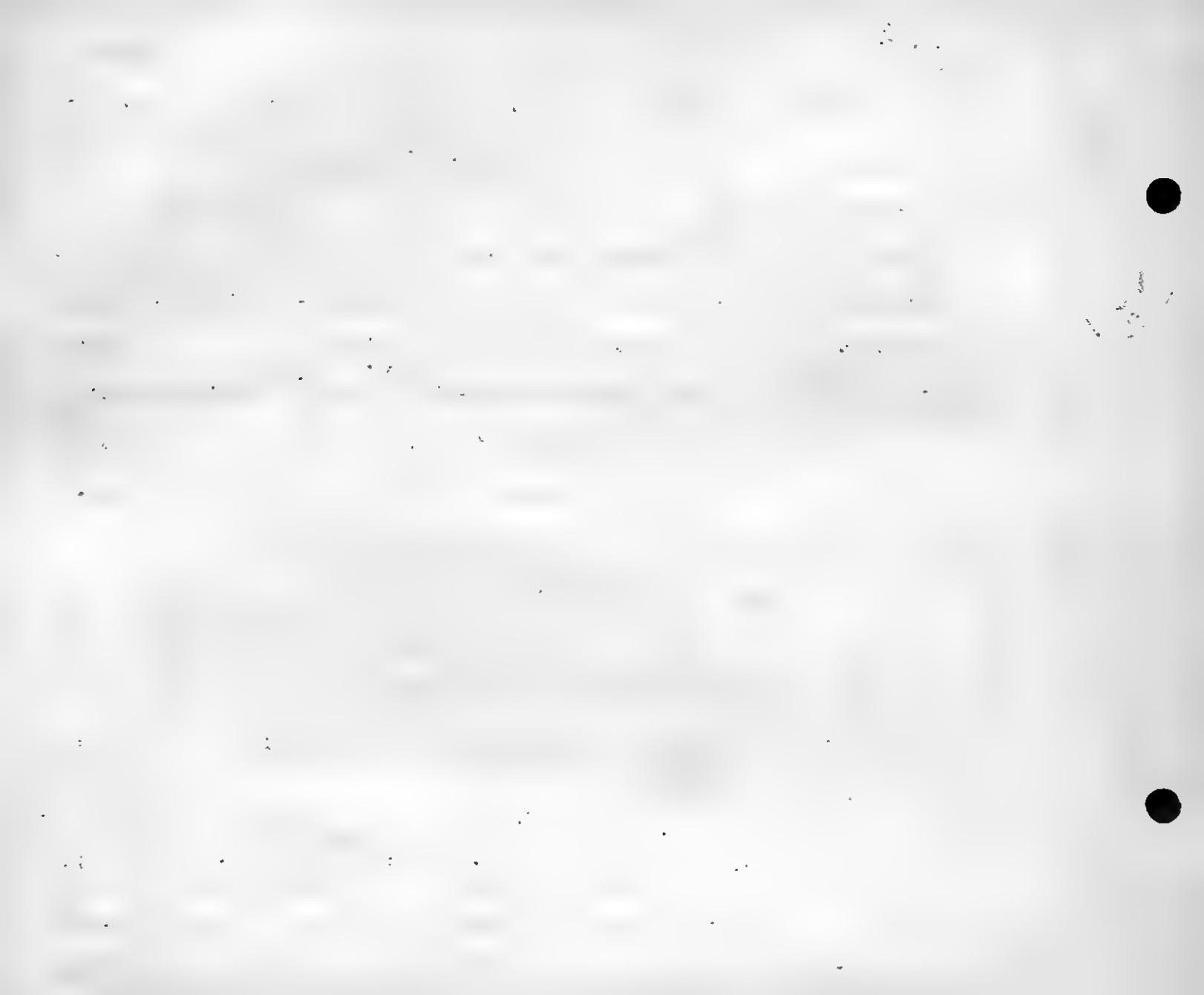
CERTIFICATE OF DEATH

14649

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper(s).
1 and 2
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Sherman	Middle (NMN)	Last Henig	20. DATE OF DEATH Month October	Day 15	Year 1968	2b. HOUR PM 6:07 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 23 January 1922		6. AGE (In years last birthday) 46 YRS.		F UNDER 1 YEAR MONTHS	TIF UNDER 24 HRS. DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Accountant		12b. KIND OF BUSINESS OR INDUSTRY US Gov't.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1218 North Belgrade Road	
14. FATHER'S NAME Moses		Middle Henig	Last	15. MOTHER'S MAIDEN NAME Sophie		Middle	Last Slonim		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO 1942-44		17. INFORMANT Bethesda, Maryland Address The Medical Records, The Clinical Center					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Bronchopneumonia, bilateral				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Chronic myelogenous leukemia				4 years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Congestive Heart Failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 31 July 1968, to 15 Oct. 1968, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 15 October 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE Robert E. Curran, MD		DEGREE MD		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 15 October 1968	
22d. PHYSICIAN'S NAME (Type)		Robert E. Curran, MD		22e. ADDRESS of health, Bethesda, Maryland The Clinical Center, National Institutes					
23a. BURIAL, CREMATION, REMOVAL (Specify) BUKRA		23b. DATE 10-16-68		23c. NAME OF CEMETERY OR CREMATORIUM KING DAVID MEMORIAL GARDEN		23d. LOCATION (City or Town) FALLS CHURCH VA			
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS - WASHINGTON DC		ADDRESS BERNARD DANZANSKY & SONS - WASHINGTON DC		25a. REC'D BY REGISTRAR DATE OCT 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14650

CERTIFICATE OF DEATH

1	14642	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14650		
CERTIFICATE OF DEATH														
1. DECEASED NAME (Type or print)		First	Middle	Last	2. DATE OF DEATH		26. HOUR							
<i>Erwin Otto Herrmann</i>					Month	Day	Year	10 P.M.						
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 18 YEARS MONTHS DAYS HOURS MIN							
MALE		WHITE	2-22-02		66	YRS	8	6						
7. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Germany		AMERICAN				MONTGOMERY Md.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY								
TAKOMA PARK		WASH SAN & Hosp.		RETIRER		Business Home								
13a. U.S.A. RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		N.W.						
13b. COUNTY		WASH. D.C.				5521 NEBRASKA AVE								
4. FATHER'S NAME First		Middle	Last	15. MOTHER'S MAIDEN NAME First		Middle	Last							
Martin			HERRMANN	Marie										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address								
No		-		PATIENTS CHART										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY EMPHYSEMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)														
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 24</u> , 19 <u>68</u> , to <u>Oct 27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Thomas P Fogarty</i>		DEGREE ATTENDING PHYS		MED DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10/29/68</u>						
22d. PHYSICIAN'S NAME (Type) <i>Thomas P Fogarty</i>		22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Burial</u> 11-1-1968		23c. NAME OF CEMETERY OR CREMATORIAL <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) <u>Silver Spring, Montgomery Co.</u>		(County)		(State)				
24. FUNERAL DIRECTOR Joseph Gowler's Sons Inc., N.W., Wash., D.C., 20016		ADDRESS 5130 Wisc. Ave.		25a. REC'D BY REGISTRAR NOV 4 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								
VR A15 (4) 30M REV. 1/68														



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Offce along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14643

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14651

1 DECEASED NAME (Type or Print)		First CHARLES	Middle Lyman	Last Hertz	2a DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	Month 10	Day 124	Year 68	2b HOUR 1:45P
3 SEX Male	4 RACE White	5 DATE OF BIRTH 11/11/39	6 AGE (In years from birthday) 28 YRS	IF UNDER 1 YEAR <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	IF UNDER 24 HRS <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month 10 Day 24 Year 68			2d HOUR 2:15P
7a BIRTHPLACE (State or foreign country) Penna.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery			Md.	
10 CITY OR TOWN OF DEATH Maryland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Construction Foreman			12b KIND OF BUSINESS OR INDUSTRY Road		
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Penna.		13c CITY OR TOWN Fairfield		13d. INSIDE CTY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER Rte. 1				
14 FATHER'S NAME William L. Hertz		15 MOTHER'S MAIDEN NAME Iva Sites							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 182-32-4403		17 INFORMANT Mrs. Dona Hertz, Fairfield, Pa. R.D. # 1			ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) x147		Multiple Extreme Injuries due to, or as a consequence of including fractured skull with Evisceration					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year 10/24 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) Released run over by dump truck while working					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or RFD No Vienna Mill Rd. at Conn. Ave., Wheaton			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Belden R. Leaph		CHIEF MEDICAL EXAMINER M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 10/24/1968		
EXAMINER'S NAME (Type) BELDEN R. LEAPH M.D. Wheaton		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS 1000 1/2 E. Main St., (county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 27, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Fairfield Union Cemetery Fairfield, Adams Co., Pa.			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Clarence E. Wilson		ADDRESS Emmitsburg, Md.		25a. REC'D BY REGISTRAR OCT 28 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14644

14652

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR		
VIRGINIA Ross		Hess			October	1	1968	1 PM		
3. SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		7b. HOURS HOURS MIN.		
Female	White	2 - 21 - 93		75 YRS						
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH						
New York	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery						
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda	Suburban Hosp			Homemaker			Own Home			
13a. USUAL RESIDENCE (Where deceased admitted, if institution) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
MARYLAND	MONTGOMERY	Bethesda	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6304 Greentree Rd.						
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
Burt	B.	Ross		Caroline	Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address							
Yes, no, or unknown	B	Opie King								
		220-32-6320	Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)										
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause DUE TO, OR AS A CONSEQUENCE OF										
(b) Coronary arteriosclerosis & myocardial DUE TO, OR AS A CONSEQUENCE OF fibrosis										
(c)										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from 9/09, 1968, to 9/30, 1968, that (I) (we) last saw the deceased alive on 9/30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.										
22b. SIGNATURE		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED		
ROBERT R. MONTGOMERY								10/1/68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
ROBERT R. MONTGOMERY		5411 CEDAR Lane Bethesda, MD								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County) (State)		
BURIAL		10/3/68		Arlington Nat'l. Cem.		Arlington,		Virginia		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland										
7557 Wisconsin Ave., RECD BY REGISTRAR					25b. REGISTRAR'S SIGNATURE					
ROBERT A. PUMPHREY, Bethesda, Maryland					OCT 7 1968 Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14653

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Anna	Middle Marie	Last Hill	2a DATE OF DEATH October Month 16 Day 1968	2b HOUR 11:25 AM
3. SEX Female	4. RACE Caucasian	5. S. DATE OF BIRTH March 11, 1891		6. AGE (In years lost boy)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or street address) Potomac Valley Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9717 Carroll Drive	
14. FATHER'S NAME First John	Middle S. Swigart	15. MOTHER'S MAIDEN NAME First Anna	Middle Last Herrick		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes or No	16b. SOCIAL SECURITY NO. 302-28-1912	17. INFORMANT John W. Kappel	Address 9717 Corral Dr. Potomac, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sev hours		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Congestive Heart Failure</u>			many months		
(c) <u>Arteriosclerotic Heart Disease</u>			many years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Bilateral pneumonia</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a I certify that (I) (this hospital) attended the deceased from <u>May</u> , 1968, to <u>Oct 16</u> , 1968, that (I) (we) last saw the deceased alive on <u>9/17</u> 1968, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <u>George H. Mitchell MD</u>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Oct. 16, 1968	
22d. PHYSICIAN'S NAME (Type) George H. Mitchell	22e. ADDRESS 11125 Rockville Pike, Rockville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/18/1968	23c. NAME OF CEMETERY OR CREMATORIUM Potomac Church Cemetery	23d. LOCATION (City or Town) Potomac	(County) Montg.	(State) Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home	ADDRESS 1831 Rockville Pike Rockville, Md.	25a. REC'D. BY REGISTRAR DATE OCT 18 1968	25b. REG STRA'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First <i>Paul</i>	Middle <i>Wayne</i>	Last <i>Hodge</i>	20. DATE OF DEATH Month <i>10</i>	Day <i>6</i>	Year <i>68</i>	26. HOUR <i>4:28 P.M.</i>
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>5-10-47</i>		6. AGE (In years lost birthday) <i>21 yrs</i>		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery County, Md.</i>				
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington San. Hosp.</i>			12a. US-JA OCCUPATION (Kind of work done during most of working life, even if retired) <i>Unemployed</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution before admission) STATE <i>maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INS-DE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>1905 Henry Road</i>			
14. FATHER'S NAME First <i>Paul</i>	Middle <i>R.</i>	Last <i>Hodge</i>	15. MOTHER'S MAIDEN NAME First <i>Eva</i>	Middle <i>Fisher</i>	Last <i></i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>217-44-9895</i>	17. INFORMANT <i>Ronald W. Seaman Step-father</i>	Address <i>Same as above</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Terminal Reticulum cell sarcomatosis</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>2000</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Reticulum cell sarcoma</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No		City or Town	County	State
22a. I certify that (I) (<i>Donald W. Datlow</i>) attended the deceased from <i>Sept 18, 1968</i> , to <i>Oct. 6, 1968</i> , that (I) (<i>Donald W. Datlow</i>) last saw the deceased alive on <i>Oct 6, 1968</i> , and that in (my) (<i>Donald W. Datlow</i>) opinion death occurred on the date and hour and from the causes stated above, (I) (<i>Donald W. Datlow</i>) did (did not) view the body after death.							
22b. SIGNATURE <i>Donald W. Datlow, M.D.</i>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>Washington San. & Hospital Takoma Park, Md.</i>		22f. DATE SIGNED <i>Oct 6, 1968</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10/10/68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Union Chapel Cemetery</i>		23d. LOCATION (City or Town) <i>Hot Springs</i>	(County) <i></i>	(State) <i>Virginia</i>
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>		25a. REC'D BY REGISTRAR <i>OCT 11 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

25

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14655

14647

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>EMMA</i>	Middle <i>D.</i>	Last <i>Hodgson</i>	2a. DATE OF DEATH Month <i>10</i>	Doy <i>30</i>	Year <i>1968</i>	2b. HOUR <i>4:50 A.M.</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>5-25-1886</i>		6. AGE (In years last birthday) <i>82</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>W. Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>				
10. CITY OR TOWN OF DEATH <i>Rockville</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Potomac Valley Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Telephone Operator</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Poolesville</i>	.3a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>—</i>			
14. FATHER'S NAME First <i>Thomas</i>	Middle <i>Hodgson</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Estelle</i>	Middle <i>J. Smith</i>	Last	Address <i>Chas. W. Elgin Poolesville MD</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>220-03-04837</i>	17. INFORMANT <i>Chas. W. Elgin</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arteriosclerosis</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive Arterosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>44.3</i>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1 May</i> , 19 <i>60</i> , to <i>20 Oct</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>17 Oct</i> , 19 <i>67</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John Murdoch Smith, M.D.</i>	DEGREE <i>M.D.</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>20 Oct 68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Constance H. Hilton Barnesville Md.</i>	22e. ADDRESS <i>Barnesv. 116, Md 20703</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10/22/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Greenway</i>	23d. LOCATION (City or Town) (County) (State) <i>Berkeley Springs W. Va.</i>				
24. FUNERAL DIRECTOR <i>Constance H. Hilton Barnesville Md.</i>	25a. REC'D BY REGISTRAR DATE <i>OCT 24 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14656

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Postage paid. Then mail. If any event, within 72 hours of death.

1. DECEASED NAME (Type or print)		First Laura	Middle Lucinda	Last Hopkins	2a. DATE OF DEATH Month 10	Day 7	Year 68	2b. HOUR 10:30 AM			
3. SEX F	4. RACE C	5. DATE OF BIRTH 8-30-82			6. AGE (In years last birthday) 86 yrs		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Md.	7b CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery						
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montg.	13c. CITY OR TOWN Sandy Spring	13d. INSIDE CITY, J.M. TSP? YES	13e. STREET AND NUMBER 18305 Brooke Rd.						
14. FATHER'S NAME Alfred	First Middle Bell	Last	15. MOTHER'S MAIDEN NAME First Eleanor	Middle	Last Hopkins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO (If yes give no. or dates of service)	17. INFORMANT			Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Home Dystrophy											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State					
22a. I certify that (I) (this hospital) attended the deceased from 1978 , to 10/7/18 , that (I) (did not) last saw the deceased alive on 10/7/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) (did not) view the body after death.											
22b. SIGNATURE 		DEGREE ATTENDING PHYS	<input type="checkbox"/>	MED DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input type="checkbox"/>	22c. DATE SIGNED 10/8/18			
22d. PHYSICIAN'S NAME (Type) Robert L Snowden Rockville Md.		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-12-68	23c. NAME OF CEMETERY OR CREMATORIAL Sharp Street Cem.			23d. LOCATION (City or Town) Sandy Spring Montg. Md.	(County) Montgomery	(State) Md.				
24. FUNERAL DIRECTOR Robert L Snowden Rockville Md.	ADDRESS Kobert L Snowden Rockville Md.	25a. RECEIVED BY REGISTRAR DATE OCT 14 1968			25b. REGISTRAR'S SIGNATURE Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14657

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>Robert</i>	Middle <i></i>	Last <i>Howard</i>	2a DATE OF DEATH Month <i>Oct</i>	Day <i>22</i>	Year <i>1968</i>	2b HOUR <i>4:30</i>
3 SEX <i>Male</i>	4. RACE <i>Tango</i>	5 DATE OF BIRTH <i>Dec 25 1900</i>			6 AGE (in years lost/birthday) <i>67</i>	IF UNDER 1 YEAR MONTHS <i></i>	IF UNDER 24 HRS. HOURS <i></i>
7a BIRTHPLACE (State or foreign country) <i>Virginia</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH <i>Montgomery</i>				
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Sibleton Hosp</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Construction</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Shoebox St.</i>	
13a JSJAC RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Mont</i>	13c CITY OR TOWN <i></i>	13d INSIDE CITY LIMIT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e STREET AND NUMBER <i>10107 Shady St.</i>			
14 FATHER'S NAME First <i>John</i>	Middle <i></i>	Last <i>Howard</i>	5 MOTHER'S MAIDEN NAME First <i>Clara</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i></i>	17 INFORMANT <i>Robert Howard Jr.</i>	Address <i>1407 Belmont N.W. Wash. D.C.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>18 hrs.</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Coronary Insufficiency</i> <i>Severe Coronary Arteriosclerosis undilated</i> <i>2 yrs</i>							
19a. DATE OF OPERATION <i>9/27/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Right RT foot</i>		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i></i>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) <i></i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i></i>		21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>
22a. I certify that (I) (this hospital) attended the deceased from <i>9/24</i> , 19 <i>68</i> , to <i>10/22</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/22</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J.R. Thistleton</i>		DEGREE <input type="checkbox"/> ATTENDING PHYS. <i></i>	<input type="checkbox"/> MED DIRECTOR <i></i>	<input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>10/23/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>J.R. Thistleton</i>		22e. ADDRESS <i>916 19th St. N.W.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10-26-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL Cem <i>Lincoln Memorial Cem</i>		23d. LOCATION (City or Town) <i>Suitland</i>	(County) <i>Prince Geo. Md.</i>	(State) <i></i>
24. FUNERAL DIRECTOR <i>R. J. ...</i>		ADDRESS <i></i>	25a. REC'D. BY REG. STRR. <i></i>		25b. REG. STRR.'S SIGNATURE <i>OCT 31 1968</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14658

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any event, within 72 hours of death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME . First NELLIE Middle DAILEY Last HOWES				2a. DATE OF DEATH Month 10 Doy 3 Year 68			2b. HOUR A.M. 9:40M				
3. SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH 9-5-11		6. AGE (In years last birthday) 59 yrs.					
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL		12c. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) OWNER & MANAGER			12b. KIND OF BUSINESS OR INDUSTRY DRESS SHOP				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GERMANTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER BOX 247, ROUTE #1			
14. FATHER'S NAME First OBER Middle - Last DAILEY		15. MOTHER'S MAIDEN NAME First MARY Middle - Last MUSGROVE									
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. -		17. INFORMANT MEDICAL RECORD DEPT.		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>284 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Electric anesthesia</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 1921					
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19c. MEDICAL CERTIFICATION DATE OF OPERATION		19d. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Oct</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 10-3-68	
22b. SIGNATURE <u>A. D. Bonifant, M.D.</u>		DEGREE		ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS					
22d. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.		22e. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 5, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Salem			23d. LOCATION (City or Town) Brookeville			(County) Mont.	(State) Md.
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville, Md.					25a. REC'D BY REGISTRAR DATE OCT 7 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14659

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First <i>HAROLD</i>	Middle <i>E.</i>	Last <i>Hughes</i>	2a. DATE OF DEATH Month 10 Day 11 Year 68	2b. HOUR M
3. SEX MALE	4 RACE White	5. DATE OF BIRTH 9-12-07		6. AGE (In years last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GROSVENOR LANE NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Teller Operator		12b. KIND OF BUSINESS OR INDUSTRY M.S.C.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13c. CITY OR TOWN Bethesda, Md.	13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5215 - 58 st Proc		
14. FATHER'S NAME First <i>Alvadore</i>	Middle <i>Hughes</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Lettie Thrash</i>	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 214-03-8012	17. INFORMANT Mildred P. Hughes	Address E. Lwendale, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Canceroma of Floor of Mouth			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> at home <input type="checkbox"/> at work at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory Office, Building, Etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (<i>this hospital</i>) attended the deceased from <i>Aug</i> , 19 <i>68</i> , to <i>10/11</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/15</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>G. Leonard Gold</i>		ATTENDING DEGREE <input type="checkbox"/> PHYS	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/11/68</i>
22d. PHYSICIAN'S NAME (Type) G. Leonard Gold		22e. ADDRESS Silver Springs, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/14/68	23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery		23d. LOCATION (City or Town) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md.		25a. RECD BY REGISTRAR DATE OCT 14 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 3 and 4 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14660

1 DECEASED NAME (Type or Print)		First ANTHONY	Middle <i>Lynne</i>	Lost HUGHLEY	2a. DATE KNOWN OF ESTI- MATED	Month <input checked="" type="checkbox"/> 10	Day 7	Year 68	2b. HOUR 5PM M	
3 SEX	4. RACE	S. DATE OF BIRTH	6 AGE (in years at birthday) 12 yrs.	IF UNDER MONTHS	YEAR DAYS	IF LINGER 24 HRS HOURS	MIN	2c. DATE PRONOUNCED DEAD Month Oct.	2d. HOUR 5PM M	
Male	Negro	12/23/50 x 1955/1286						7 Day 7	Year 68	
7a BIRTHPLACE (State or foreign country) No. Carolina		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b. KIND OF BUSINESS OR INDUSTRY School				
13a. USUAL RESIDENCE (Where deceased lived, if institut. on. Residence before admission) STATE Md.		13c. CITY OR TOWN Montgy.		13d. NEAR CITY LIMITS?		13e. STREET AND NUMBER 1013 S. Belgrade Road				
14. FATHER'S NAME First Emory		Middle Hughley	Lost	15. MOTHER'S MAIDEN NAME First Carrie		Middle B.	Lost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO None		17. INFORMANT Father, Emory Hughley		ADDRESS 1013 S. Belgrade Rd. S.S., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries Severe - DUE TO, OR AS A CONSEQUENCE OF 817 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma from Blow from Auto - DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None										
19a. MEDICAL CERTIFICATION DATE OF OPERATION 10/7/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 4:30 P.M.		21b. TIME OF INJURY Month, Day, Year 10/7 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Struck by car when ran into Street.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION STREET or R.F.D. No. 1170 Arcola St.		City or Town Silver Spring Mort. Md.		County Montgomery		State Md.
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED Oct. 7, 1968.
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) John G. Ball		CHIEF MEDICAL EXAMINER MD		ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county) Prince Georges, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-11-1968		23c. NAME OF CEMETERY OR CREMATORIAL St. Lincoln Cemetery		23d. LOCATION (City or Town) OCT 11 1968		(County) (State) Prince Georges, Maryland		
24. FUNERAL DIRECTOR C. Glen Carter		ADDRESS Sil. Spr. Md.		25a. REG'D. BY REGISTRAR Warren E. Humphrey, Inc.		25b. REGISTRAR'S SIGNATURE Charles Judge				
VR A15ME (5) TOM REV. 1/66										

2007



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14658

CERTIFICATE OF DEATH

14661

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>Lola</i>	Middle <i>Nevada</i>	Last <i>Hurd</i>	2a DATE OF DEATH Month <i>Oct</i>	Day <i>1</i>	Year <i>1968</i>	2b HOUR <i>14:30</i>		
3 SEX <i>F</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>6-24-76</i>	6 AGE (in years last birthday) <i>92</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i>	IF UNDER 24 HRS MIN. <i>0</i>		
7a BIRTHPLACE (State or foreign country) <i>Del</i>	7b CITIZEN OF WHAT COUNTRY? <i>Amer</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH <i>Montgomery</i>						
10 CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington San & Hospital</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>H.S.W.T.</i>	12b KIND OF BUSINESS OR INDUSTRY <i>NONE</i>						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>	13c CITY OR TOWN <i>Montgomery Takoma Park</i>	13d. INSIDE CITY L.H.T.S? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <i>909 Domer Ave</i>						
14 FATHER'S NAME First <i>Chas</i>	Middle <i>R.</i>	Last <i>Hayton</i>	15 MOTHER'S MAIDEN NAME First <i>Margaret</i>	Middle <i>Sipple</i>	Last <i>Sipple</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b SOCIAL SECURITY NO <i>222-20-8592</i>	17 INFORMANT <i>Hospital Records</i>	Address						
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory failure & Cardiac arrest</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5-10 min</i>			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Multiple fractures & Overwhelming Shock</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Multifocal fractures & Overwhelming Shock</i>						7 days			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sensitivity</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus fracture of right clavicle, 7 ribs & Right</i>									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY YES <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR AM PM <i>Sept 24 1968</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Patient fell in her bedroom.</i>							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>home</i>	21f LOCATION Street or R.R. No <i>909 Domer Ave</i>	City or Town <i>Takoma Park</i>	County <i>Mont.</i>	State <i>Md.</i>				
22a. I certify that (1) (this hospital) attended the deceased from <i>Sept 24, 1968</i> , to <i>Oct 1, 1968</i> , that (1) (we) last saw the deceased alive on <i>Oct 1, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Wilford D. Meyers M.D.</i>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>Oct 1, 1968</i>					
22d. PHYSICIAN'S NAME (Type) <i>Wilford D. Meyers M.D.</i>	22e. ADDRESS <i>8333 Haddon Drive</i>	22f. CITY OR TOWN <i>Takoma Park</i>	22g. COUNTY <i>Mont.</i>	22h. STATE <i>Md.</i>					
23a BURIAL/CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE <i>Oct. 4, 1968</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Barratt's Chapel Cem.</i>	23d. LOCATION (City or Town) <i>Frederica</i>	(County) <i>Kent</i>	(State) <i>Delaware</i>				
24 FUNERAL DIRECTOR <i>William B. Myers Jr., Wilford, Del.</i>	ADDRESS <i>William B. Myers Jr., Wilford, Del.</i>	25a REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

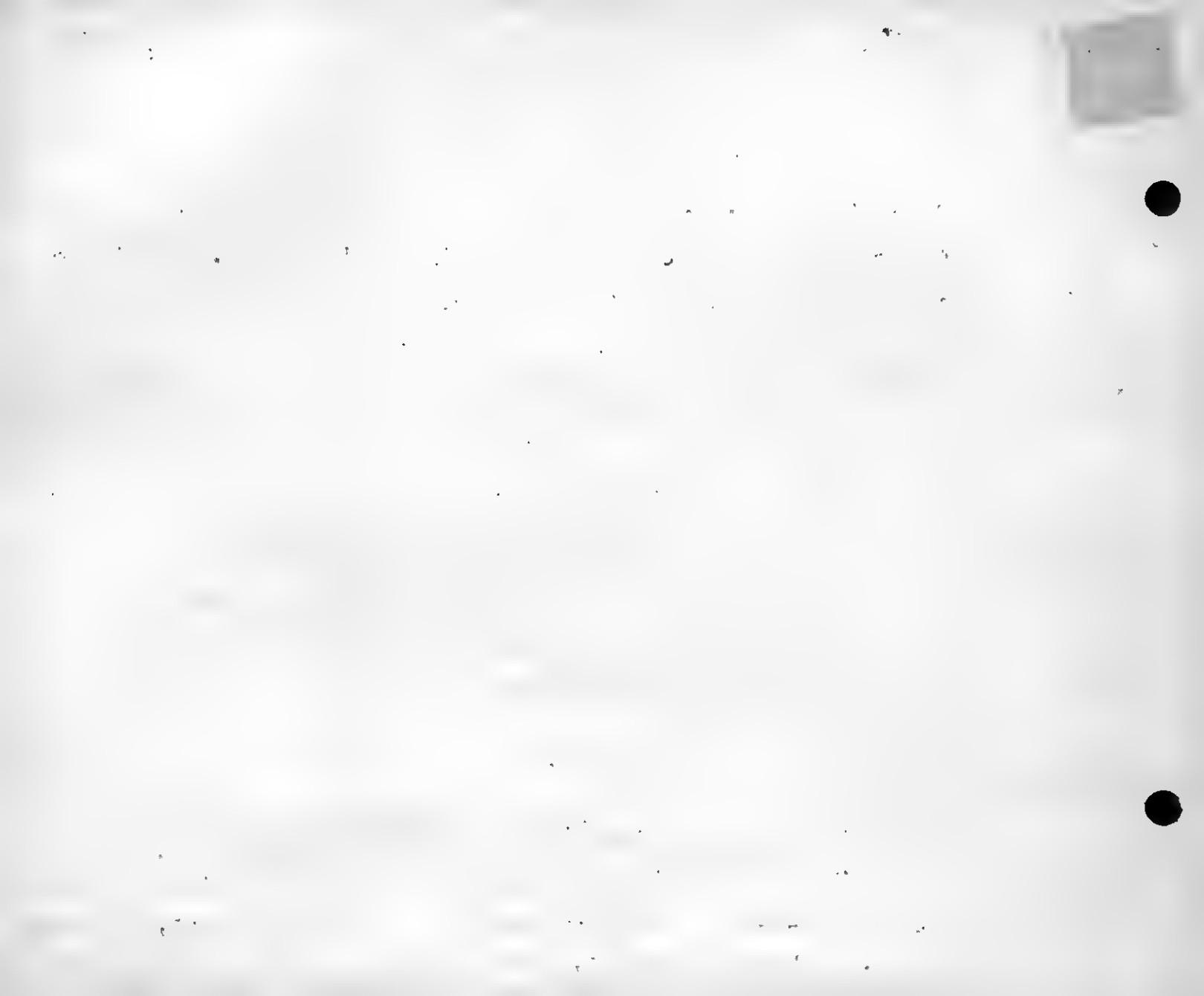
CERTIFICATE OF DEATH

NOT TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NOT TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

70 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b. HOUR 8:50 AM		
Claude G. Inman						10	5	68			
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)			IF UNDER 24 HRS MONTHS DAYS		
Male		Caucasian		1/26/08		60					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
England		U. S.		<input checked="" type="checkbox"/> NEVER MARRIED	<input type="checkbox"/>	Montgomery			Retired		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		13a. STREET AND NUMBER			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring		St. Luke's Hospital		Gov't Employee.		7004 Georgia St.			Retired		
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			Md.		
Maryland		Montgomery County		<input type="checkbox"/> YES	<input type="checkbox"/> NO	7004					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Oliver				Joyce	unknown		unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) no					16b. SOCIAL SECURITY NO.		17. INFORMANT			Address	
					unknown		Harold Inman			704 George St Chevy Chase, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple pulmonary emboli</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few weeks DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypernephroma</u> years DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
22d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County	State	
22o. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>68</u> , to <u>Oct 15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		G. Leonard Gold			DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)		G. LEONARD GOLD			22e. ADDRESS		9801 Georgia Ave. Silver Spring, Maryland				
23e. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION (City or Town)		(County)	(State)	
Burial		10-8-68		Gate of Heaven			Silver Spring, Maryland				
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
ROBERT A. PUMPHREY, Bethesda, Maryland					DATE OCT 9 1968		Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14663

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)	First <i>ANNA</i>	Middle <i>M.</i>	Last <i>Jackson</i>	2a DATE OF DEATH Month <i>Oct</i>	Day <i>24</i>	Year <i>1968</i>	2b HOUR <i>4:05 P.M.</i>		
3 SEX <i>FEMALE</i>	4. RACE <i>WHITE</i>	5 DATE OF BIRTH <i>2/28/82</i>	6 AGE (In years last birthday) <i>86</i>	F JUNIOR 1 YEAR MONTHS DAYS HOURS MIN					
7a BIRTHPLACE (State or foreign country) <i>Wisconsin</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>MONTGOMERY</i>						
10 CITY OR TOWN OF DEATH <i>BETHESDA</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>SUBURBAN</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	12b KIND OF BUSINESS OR INDUSTRY						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>	13b COUNTY <i>MONTGOMERY</i>	13c CITY OR TOWN <i>CHEVY CHASE</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>6913 RIDGEWOOD AVE.</i>					
14 FATHER'S NAME First <i>JOSEPH</i>	Middle <i>JEROME</i>	Last <i>ADAMS</i>	15. MOTHER'S MAIDEN NAME First <i>CARRIE</i>	Middle <i>H</i>	Last <i>BRAHMSTEAD</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>213-56-7589</i>	17 INFORMANT (HUSBAND) <i>HARTLEY JACKSON</i>	Address <i>Chevy Chase, MD 20815</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>4109</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4201</i>						Myocardial infarction, recent and remote DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerosis, generalized, severe</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Reticulum cell sarcoma</i>									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes.</i>				
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJ. OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No	City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from <i>26 April, 1968</i> , to <i>date</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>26 April, 1968</i> , and that in (my) (<input type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (<input type="checkbox"/>) view the body after death.									
22b. SIGNATURE <i>John E. Ball</i>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>Oct 25, 1968</i>					
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal-Burial</i>	23b DATE <i>10-28-1968</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Evergreen Cemetery Cem.</i>	23d LOCATION (City or Town) <i>Milton, Wisconsin</i>	(County)	(State)				
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>OCT 30 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14664

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1	14656			2. DATE OF DEATH Oct. 28 Month Day 28 Year 68										2b. HOUR 345 A.M.
1. DECEASED-NAME (Type or print)			First Helen	Middle Karst	Last JACKSON	5. DATE OF BIRTH Aug. 29, 1922			6. AGE (in years last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN	
3. SEX Female			4. RACE Caucasian			7. CITIZEN OF WHAT COUNTRY? USA			B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
7a. BIRTHPLACE (State or foreign country) Florida			7b. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13c. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE Florida			13d. CITY OR TOWN Maitland			13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 241 Dommerich Drive						
14. FATHER'S NAME Emil E. Karst			15. MOTHER'S MAIDEN NAME Bessie Furbeck											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 263 242571			17. INFORMANT Maitland			Address Fla.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			Septicemia associated with acute peritonitis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b)											
			DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)														
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> or work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County	State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jul. 24, 1968, to Oct. 28, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.														
22b. SIGNATURE Donald K. Roeder, M.D.		22c. DATE SIGNED Oct. 28, 1968												
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Naval Hospital, Bethesda, Md.												
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE 10-30-68			23c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery			23d. LOCATION (City or Town) Orlando,		(County) Fla.	(State)			
24. FUNERAL DIRECTOR Danzansky Funeral Home 3501 14th St., N. W. Washington, D. C.					25a. REC'D. BY REGISTRAR DATE OCT 30 1968			25b. REGISTRAR'S SIGNATURE Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

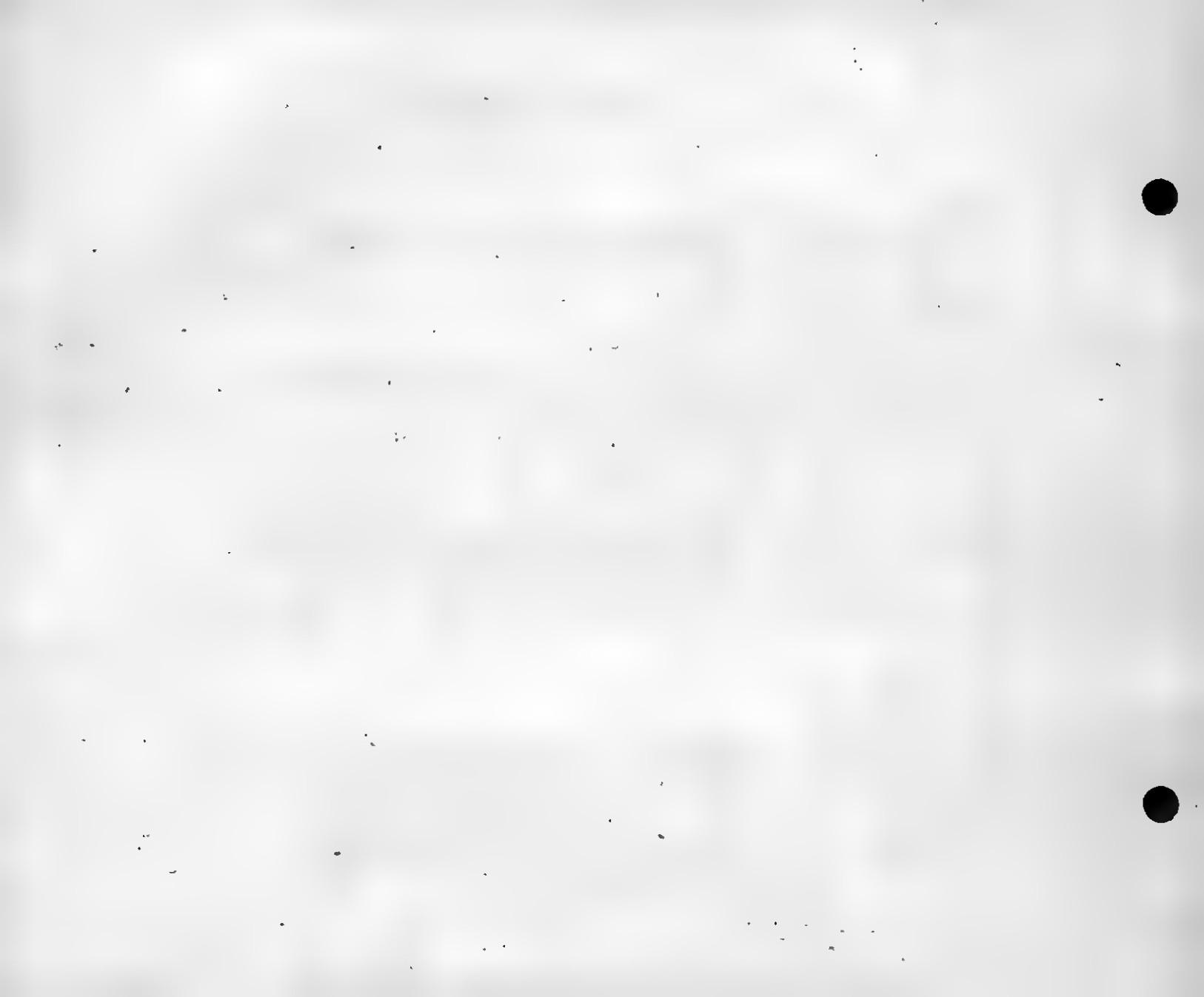
CERTIFICATE OF DEATH

14665

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If you need more carbon paper, contact the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Eva	Middle (NMM) Jaczko	Last	2a. DATE OF DEATH Month October 27	2b. HOUR Year 1968 12:45	
3. SEX Female	4. RACE White	5. DATE OF BIRTH June 25, 1882		6. AGE (In years lost birthday) 88 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Hungary	7b. CITIZEN OF WHAT COUNTRY? Hungary	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired.) Housewife		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before address on) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 11503 Alma Street	
14. FATHER'S NAME Francis	First Middle Michael	Lost Kieskey	15. MOTHER'S MAIDEN NAME Mary	Middle Teleky	Last Dobeky	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 278-09-3215-B	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myelogenous Leukemia 205 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 204						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 17, 1968, to October 21, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 21, 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.						
22b. SIGNATURE David A. Bray MD		22c. DATE SIGNED 27 October 1968				
22d. PHYSICIAN'S NAME (Type) David A. Bray, M.D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL, (Specify)	23b. DATE 10-30-1968	23c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cemetery	23d. LOCATION (City or Town) Si. Se. Mo. Maryland Md.	(County)	(State)	
24. FUNERAL DIRECTOR C. Glen Carter Funer. E. Pumphrey, Inc. 8431 Ga. Ave.	ADDRESS <input type="checkbox"/> 1. Sn. Ad.	25a. REC'D BY REGISTRAR OCT 31 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



14658

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal; and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN OF ESTIMATE DEATH MATED	Month	Day	Year	2b HOUR 12:20			
	Joan	K	Jenkins	<input checked="" type="checkbox"/>	10-27	1968					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS			2a HOUR 12:20			
female	white	July 18, 1938	30 yrs	MONTHS	DAYS	HOURS	MIN				
7a BIRTHPLACE (State or Foreign country)	7b CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9 COUNTY OF DEATH				2a HOUR 12:20			
Baltimore	U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Montgomery							
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY						
Silver Spring	Holy Cross Hospital										
13a USUAL RESIDENCE (Where deceased lived, if institutional admission) STATE	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER	Aladdin Drive							
Maryland	HOWARD	<input checked="" type="checkbox"/> NO <input type="checkbox"/>	1520 Aladdin Dr,								
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last				
Thomas N. Eagleton				Josephine Cuneo							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS								
(If yes give war or dates of service)		Robert E. Jenkins, husband, above									
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to aspiration											
DUE TO, OR AS A CONSEQUENCE OF											
Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) of gastric contents											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR <input checked="" type="checkbox"/> 11:50 AM		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased vomited and aspirated vomitus		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No Laurel		City or Town Howard		County Md.		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		BELDEN A. REAP M.D. <i>Belden A. Reap</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>10/27/1968</i>			
EXAMINER'S NAME (Type)		ADDRESS Belair Memorial Gardens			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS Belair Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/31/68		23c. NAME OF CEMETERY OR CREMATORIAL Belair Memorial Gardens		23d. LOCATION (City or Town) Belair Md.		(County)			(State)
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		ADDRESS			25a. REC'D BY REGISTRAR DATE OCT 30 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

14659 Item 13e Film GL06 10/22/68
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14667

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours of a death.

1. DECEASED NAME (Type or print)	First Carl	Middle A.	Last Johnson	2a. DATE OF DEATH Month October	Day 18	Year 1968	2b. HOUR M 4:00
3. SEX Male	4. RACE White	5. DATE OF BIRTH 23 August 1916			6. AGE (In years last birthday) 52 yrs.		
7a. BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Restaurant Owner			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Ohio	13b. COUNTY	13c. CITY OR TOWN W. Carrollton	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 713 South Elm Street			
14. FATHER'S NAME Grover	First C.	Middle Johnson	Last	15. MOTHER'S MAIDEN NAME Lillian	Middle M.	Last Adams	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 379-09-0189	17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Degeneration and impaction of silicone prosthetic/</u>				<u>aortic valve</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				<u>anterolateral myocardial infarction</u>			7 weeks
				<u>(c) Rheumatic heart disease</u>			20 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION 4201	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>23 August, 1968</u> , to <u>18 Oct., 1968</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>18 October 1968</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <i>Ronald M. Abel, M.D.</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/> 22c. DATE SIGNED 18 October 1968
22d. PHYSICIAN'S NAME (Type) Ronald M. Abel, M.D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 22, 68	23c. NAME OF CEMETERY OR CREMATORIUM Woodland Cemetery			23d. LOCATION (City or Town) Zenia Greene	(County) Ohio	(State)
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 Rockville Pike, Rockville, Maryland				ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 22 1968	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

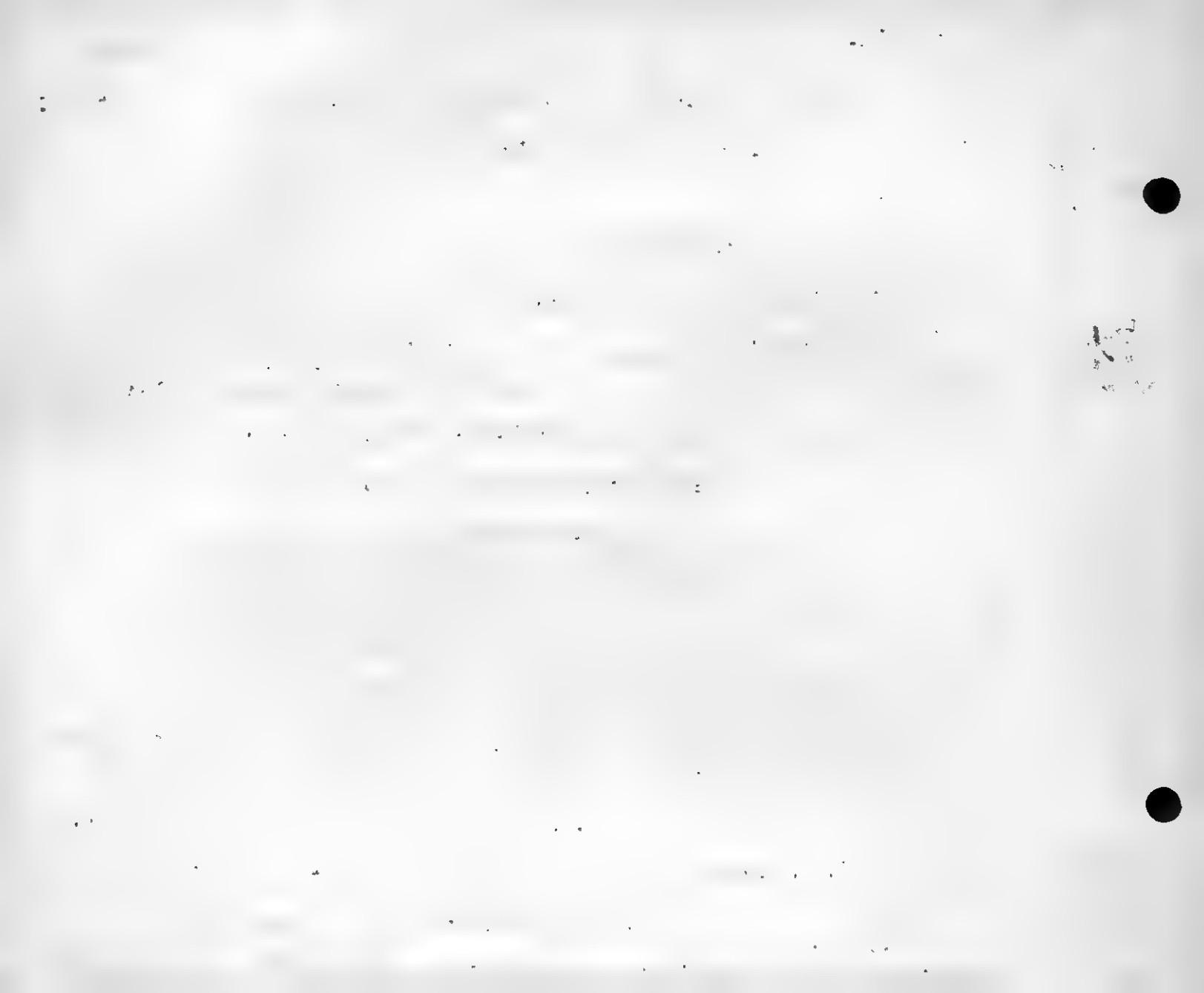
CERTIFICATE OF DEATH

14668

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print) Jeffrey Miles JOHNSON				2a. DATE OF DEATH Month Day Year October 8 1968	2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 68 900P M
3. SEX Male		4. RACE Caucasian	5. DATE OF BIRTH March 18, 1961	6. AGE (In years last birthday) 7 YRS.	
7a. BIRTHPLACE (State or foreign country) California		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital the street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13c. CITY OR TOWN Quantico	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Quarters 2780-C	
14. FATHER'S NAME Harold Larue Johnson		15. MOTHER'S MAIDEN NAME Catherine Mary Hanlin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NYA		16b. SOCIAL SECURITY NO. 	17. INFORMANT Quantico, Va.	Address Harold Larue Johnson, Quarters 2780-C, MCB	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema secondary to Uremia					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5933					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Secondary to Uremia (Clinical) due to					
DUE TO, OR AS A CONSEQUENCE OF (c) Obstructive Uropathy					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Liver x					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> D. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No City or Town	County	State
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from Oct. 5, 1968, to Oct. 8, 1968, that <input type="checkbox"/> (we) last saw the deceased alive on Oct. 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.					
22b. SIGNATURE Janeed Snyder M.D. DEGREE		22c. DATE SIGNED Oct. 9, 1968			
22d. PHYSICIAN'S NAME (Type) J. L. Snyder		22e. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 14 Oct. 68	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR John Mountcastle		ADDRESS Cunningham Mount Castle	25a. REC'D BY REGISTRAR Occoquan & Harner St.		25b. REGISTRAR'S SIGNATURE OCT 14 1968 Charles Judge
Funeral Home		Woodbridge, Virginia			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

14662

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14669

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- MATED	Month	Day	Year	2b. HOUR	
<i>Charles Harvey Jones</i>						<input checked="" type="checkbox"/>	Oct	28	1968	9:20 AM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 24 HRS	8 IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD	Month	Day	Year	2d. H.O.R.	
Male	White	5-23-43	25 yrs	MONTHS	DAYS	HOURS	MIN				
7a. BIRTHPLACE (State or foreign country)		7b. CIT.ZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH					
<i>Maryland</i>		<i>U.S.A.</i>		<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		<i>Montgomery</i>					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if not regular)			12b. KIND OF BUSINESS OR INDUSTRY		
<i>Bethesda</i>			<i>Suburban Corp. Worker</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
<i>Md.</i>			<i>Bladensburg</i>			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			<i>4317 37th Ave</i>		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
<i>Thomas</i>			<i>E.</i>	<i>Jones, Sr.</i>		<i>Violet</i>			<i>L.</i>	<i>Thomas</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
			<i>220-440-7034</i>			<i>bra Lee Jones Bladensburg, Md</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive intra-pulmonary hemorrhage, right</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Fracture of right rib cage</i> (b) <i>Puncture wounds from fractured ribs</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Trauma from accidental fall down elevator shaft</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>Oct 28 1968</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fall down elevator shaft at work.</i>					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, off ce building, etc.) <i>Office building</i>			21f. LOCATION Street or R.F.D. No. CITY or Town <i>Peerless</i>			County <i>Montgomery</i>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John G. Ball</i>			EXAMINER'S NAME (Type) <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>Lanham, Pro Geo Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Oct 31, 1968			23c. NAME OF CEMETERY OR CREMATORIAL Whitfield Cemetery			23d. LOCATION (City or Town) (County) (State) Lanham, Pro Geo Md.		
24. FUNERAL DIRECTOR F. Gasch's Sons			ADDRESS Hyattsville, Md.			25a. REC'D. BY REGISTRAR DATE NOV 1 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 7b Filmed 7/29/68

CERTIFICATE OF DEATH

14670

1. DECEASED NAME (Type or print)	First Gertrude	Middle Evelyn	Last Jones	2a. DATE OF DEATH Month October	Day 17	Year 1968	2b. HOUR P 11:50 M		
3. SEX Female	4 RACE White	5. DATE OF BIRTH 2/26/84		6. AGE (In years last birthday) 84	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS MONTHS 0	IF UNDER 1 HRS DAYS 0	MIN 0	
7a. BIRTHPLACE (State or foreign country) England	7b. CITIZEN OF WHAT COUNTRY? ? England	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. US/JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Damascus	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9886 Main street					
14. FATHER'S NAME First Robert Watson	Middle	Last	15. MOTHER'S MAIDEN NAME First Anna	Middle	Last Truckette				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 129-38-8103	17. INFORMANT records Montgomery General Hospital, Olney, Md.	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent Cerebral Thrombosis							12 days		
DUE TO, OR AS A CONSEQUENCE OF Cerebral Arteriosclerosis							15 years		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Arteriosclerotic Cardiovascular Disease							15 years		
DUE TO, OR AS A CONSEQUENCE OF lost. 4221									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
1. Acute Pneumonitis 2. Diabetes Mellitus									
19a. DATE OF OPERATION No Operation	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) No Injury							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State				
22a. I certify that (I) (initials) attended the deceased from July 12, 1968 , to October 17, 1968 , that (I) (initials) last saw the deceased alive on October 17, 1968 , and that in (my) (initials) opinion death occurred on the date and hour and from the causes stated above, (I) (initials) (did) (initials) view the body after death.									
22b. SIGNATURE <i>Karen Boyer</i>	DEGREE M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED October 18, 1968					
22d. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.	22e. ADDRESS 9701 Church Street, Damascus, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 20, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Damascus Meth.	23d. LOCATION (City or Town) Damascus, Md.	(County)	(State)				
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 22 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14671

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file in the burial-tranit permit. Then please remove carbon copies. Page one, 2 director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon copies. Page one, 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First IRENE	Middle CAMPBELL	Last JONES	2a. DATE OF DEATH Month OCT.	Day 31	Year 1968	2b. HOUR 8 P M		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH AUG. 8, 1889		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		Md.			
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MAPLE AVE.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) REF. - U.S. GOVT.		12b. KIND OF BUSINESS OR INDUSTRY GOVT.				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.	13b. COUNTY MONTG.	13c. CITY OR TOWN TAKOMA PK.	13d. INSIDE CTY. LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 7777 MAPLE AVE.					
14. FATHER'S NAME First —	Middle BRADLEY	15. MOTHER'S MAIDEN NAME First Middle —							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown —	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 216-46-1395	17. INFORMANT ALLAN L. DREW, II, BOWIE, MD.		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Convey Nervous DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Extraordinary Heat Stroke DUE TO, OR AS A CONSEQUENCE OF (c) Delects Nellotz						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 260X									
19a. DATE OF OPERATION 260X	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 327						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No	City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 327 , 1968, to 10/31 , 1968, that (I) (we) last saw the deceased alive on 10-25-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22b. SIGNATURE G. Betz			
22d. PHYSICIAN'S NAME (Type) ANDREW J. BETZ	22e. ADDRESS 2906 WELLER RD, SILVER SPRING, MD.		22f. DATE SIGNED 11-1-68						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11/4/68	23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN	23d. LOCATION (City or Town) SILVER SPRING, MD.		(County) —		(State) —		
24. FUNERAL DIRECTOR JOS. GAWLER'S SONS, 5130 WIS. AVE., WASH., D.C.	ADDRESS —		25a. REC'D. BY REGISTRAR NOV 7 1968	25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14672

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Harold W. Draper, M.D.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 7:30 P.M.			
LORRAINE H. JONES							10	25	68				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday) 59 59 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
F.		W.		5/20/09			59						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
D.C.		U.S.A.					MONT.						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if not in job) Rent Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY Service		
SILVER SPRING				HOLY CROSS Hosp.									
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Md.		MONT.		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10309 INSLEY ST.					
14. FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME-First	Middle	Last				
Gordon						Heirs	Martha		Eva	Project			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address: 10309 Insley Street, Md.							
No		WES		Reverelle D.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardio-respiratory arrest													
DUE TO, OR AS A CONSEQUENCE OF (b) Embolism; electrolyte imbalance													
DUE TO, OR AS A CONSEQUENCE OF (c) Biliary cirrhosis													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours.													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DAYS.													
2 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)													
5810													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from December 1967 , to October 25, 1968 , that (I) (we) last saw the deceased alive on October 25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE <i>Harold W. Draper, M.D.</i>		22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED 10/25/68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 9801 Ga. Ave. Silver Spring											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-27-1968		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION (City or Town) Primo Geyson, Maryland		(County)		(State)			
23e. MEDICAL DIRECTOR <i>C. Glen Carter</i>		23f. ADDRESS Sil. Snr. Md.		23g. REC'D BY REGISTRAR OCT 31 1968		23h. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
VR A15M 30M REV 1-88													



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14665

14673

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	20. DATE OF DEATH Month	Day	Year	2b. HOUR			
		<i>Thomas WALTER JONES</i>			10	10	1968	5:25 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male		White		12/16/1944		73 yrs					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Montgomery Co.			
D.C.		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospital				8107 EASTERN AVE.					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Md.		Montgomery		SL. SP		8107 EASTERN AVE.					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
William E. JONES					Ann A. HAGAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No				Hospital Records.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia & Congestive Heart Failure</i>										2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Aspiration</i> .											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> Yes					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/23</i> , 19 <i>60</i> , to <i>10/19</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/19</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <i>Bernard A. Heckman, M.D.</i>										22c. DATE SIGNED <i>10/10/68</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Bernard A. Heckman		8107 Eastern Ave., Silver Spring,									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County) (State)			
10-14-68		MT. OLIVE				WASH.		D.C.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D. BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE					
Henlon Funeral Home 4748 Wisc. Ave.				OCT 15 1968		<i>Charles Judge</i>					



FOR STATE
HEALTH DEPT.

delay is
necessary, please execute this certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

14668

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14674

1 DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month	Day	Year	2b HOUR ? M	
2c DATE PRONOUNCED DEAD Month	Day	Year	2d HOUR ? M						
3 SEX 7e.	4 RACE W.	5 DATE OF BIRTH Nov 191894	6 AGE (in years last birthday) 73 yrs	F UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN		
7a BIRTHPLACE (State or foreign country) Great Britain	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery						
10. CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) 8700 Colesville Rd.	12a USUAL OCCUPATION (Kind of work done during most working life even if retired) Housewife	12b KIND OF BUSINESS OR NO STRY own home						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13c CITY OR TOWN Montgomery Silver Spring	13d INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 8700 Colesville Rd. Apt. 6						
14 FATHER'S NAME (Unknown)	First	Middle	Last	15. MOTHER'S MAIDEN NAME (Unknown)	First	Middle	Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16b SOCIAL SECURITY NO. (If yes give war or dates of service) None	17 INFORMANT Mr. J. Robert Taylor	ADDRESS Wheaton, Maryland 2601 Univ. Blvd.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Infarction cerebrum 403.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 225									
19a. DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								22b DATE SIGNED Oct 4, 1968	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 10-8-1968	23c NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery	23d LOCATION (City or Town) Arlington	(County)	(State)	Virginia			
24. FUNERAL DIRECTOR M. Andrew Duvall Warren E. Pumphrey, Inc.	ADDRESS 8434 Georgia Avenue	REC'D BY REGISTRAR M. E. REC'D BY REGISTRAR DATE OCT 10 1968	REGISTRAR'S SIGNATURE Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14667

14675

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any part of the original remains, do not remove, and mail event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Mirian	Middle Z.	Last Kaitlin	2a. DATE OF DEATH 10 Month 4 Day 68 Year 12:05 AM	2b. HOUR			
3. SEX Female		4 RACE White		5. DATE OF BIRTH Jan. 15, 1923		6. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital address) Washington San. & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Receptionist		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spgs.	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 11617 Lockwood Dr.				
14. FATHER'S NAME Morris		Middle Zola	15. MOTHER'S MAIDEN NAME Sadie		Middle Fell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO.		17. INFORMANT Brother Joseph Zola - 11338 Cherry Hill		Address Beltsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART 1 DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		BRAIN STEM COMPRESSION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) RUPTURED INTRACRANIAL ANEURYSM		INFRACCEREBRAL HEMORRHAGE		3 days			
		DUE TO, OR AS A CONSEQUENCE OF (c) SOCCULAR ANEURYSM		CONGENITAL					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1968, to Oct. 1968, that (I) (we) last saw the deceased alive on Oct. 3 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John Thomas Lord</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/4/68				
22d. PHYSICIAN'S NAME (Type) John Thomas Lord		22e. ADDRESS 1015 Spring St Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-9-68	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.		23d. LOCATION (City or Town) Arlington, Virginia		(County)		
24. FUNERAL DIRECTOR B. Danzansky & Sons Washington, DC		ADDRESS		25a. REC'D BY REGISTRAR OCT 10 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. **Do not** file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 3:30 P.M.		
Heba		J		Kelleam	10	13	68	3:30 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER MONTHS YEAR HOURS MIN		
Female	White	6/8/01			67 yrs.		4	4	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Miss.		U.S.A.				Montgomery Co., Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR ADULTERY Rentals		
Silver Spring, Md.		Holy Cross Hosp.			Rental Clerk				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Montgomery Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11531 Lovejoy St.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		Address		
Bulus		M.	Parker	Amanda	J.		55, Mrs. Elaine E. Finklea 11531 Lovejoy St. Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		yes		Mrs. Elaine E. Finklea		7 days			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <i>Pneumonia lobar bilateral</i>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a)									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
10/11/68		Tracheotomy Respiratory failed			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 10/12, 1968, to 10/13, 1968, that (I) (we) last saw the deceased alive on 10/13, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <i>Ralph F. Patterson MD</i>		DEGREE ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED 10/13/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 1407 Madison Avenue, Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/16/68		23c. NAME OF CEMETERY OR CREMATORIAL Llano Cemetery		23d. LOCATION (City or Town) Amarillo, Texas		(County) (State)	
24. FUNERAL DIRECTOR J. Lee Jude		ADDRESS 8434 Georgia Avenue Warren E. Purphrey, Inc. Silver Spring, Md.		25a. REC'D. BY REGISTRAR OCT 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pen in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14677

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH MATED	Month	Day	Year	2b. HOUR	
		OLIVER STEWART KERN			<input checked="" type="checkbox"/>	10-11	168		4:15pm	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS DAYS	9. 2c. DATE PRONOUNCED DEAD Month	10. Day	11. Year	2d. HOUR	
Male	White	12-5-86	81 YRS			10	11	1968	4:15pm	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. COUNTY OF DEATH				
New York		U.S.A.		<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED		Montgomery			Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park		Wash. San. & Hosp.			Engineer			Electrical		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS	13e. STREET AND NUMBER				
Md.		Mont.		Rockville	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	717 Maple Ave.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
		Unknown			Grandson			Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No)		16b. SOCIAL SECURITY NO. (Mo. of war or dates of service)		17. INFORMANT			ADDRESS			
Yes		152-09-0220A		Mr. Allen Kern, 717 Maple Ave., Rockville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial. Infarction</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4179 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Coronary Occlusion. Acute -</i>										5 hr.
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerosis. Generalized -</i>										5 hr. - years.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.			City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		<i>John G. Ball</i>			M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)		<i>John G. Ball</i>			M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22b. DATE SIGNED <i>Oct. 11, 1968.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>10-15-1968</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cemetery</i>			23d. LOCATION (City or Town) <i>Washington, D. C.</i>		(County) (State)	
23e. FUNERAL DIRECTOR <i>C. Glen Carter</i>		ADDRESS <i>Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.</i>		25a. REC'D BY REGISTRAR <i>OCT 21 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



~~7~~ FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 406 MARYLAND STATE DEPARTMENT OF HEALTH
11-19-68ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14678

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTL- DEATH MATED	Month	Day	Year	2b HOUR
Herbert			Sam	Kidd		10-23	168	8:10A		
3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (in years less birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS					
Male	White	10-18-10	58 yrs	MONTHS	DAYS	HOURS	MIN			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH		2c DATE PRONOUNCED DEAD Month Day Year		
Ala		Amer		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		2d HOME 8:10A M		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDSTRY	
Takoma Park			Wash San & Hospital			plumber				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland			Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	9115 Bradford Rd		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last	
Zachariah					Kidd					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
Yes			579 03 9607			Hosp record				
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY-										
IMMEDIATE CAUSE (a) Acute pulmonary emboli APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) accompanied by pneumonitis										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
5X										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Belden R. Reeb M.D.</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <i>BELDEN R. REEB M.D.</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Please type or print county) <i>10/23/1963</i>										
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE Oct. 25, 1968			23c NAME OF CEMETERY OR CREMATORIUM Baltimore National			23d LOCATION (City or Town) (County) (State) Baltimore Md	
24 FUNERAL DIRECTOR			ADDRESS <i>J. Arden Walters, 254 Carroll St NW. DC</i>			25a REC'D BY REGISTRAR			25b REG-STAR'S SIGNATURE <i>Charles Judge</i>	
						DATE OCT 28 1968				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

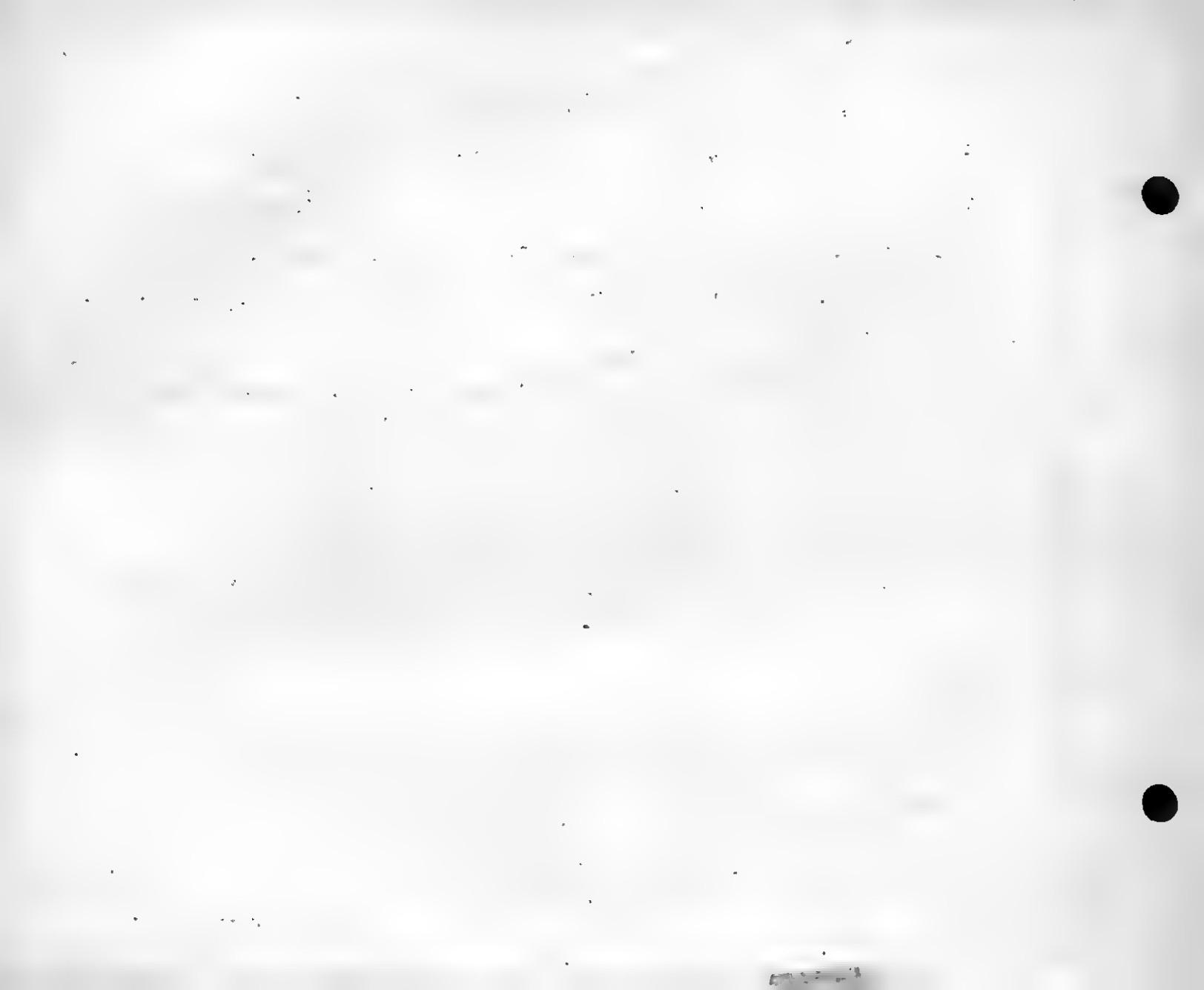
CERTIFICATE OF DEATH

14679

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First JOHANNA	Middle KILSHIMER	Last KILSHIMER	20. DATE OF DEATH Month OCT	Day 5	Year 1968	2b HOUR 3:50 PM
3. SEX FEMALE	4 RACE WHITE	S. DATE OF BIRTH 8-10-04	6. AGE (in years lost birthday) 64 YRS	IF UNDER 1 YEAR MONTHS 0			
7a. BIRTHPLACE (State or foreign country) GERMANY	7b. CITIZEN OF WHAT COUNTRY? U.S.A	B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH MONTGOMERY	IF UNDER 24 HRS. MONTHS 0			
10. CITY OR TOWN OF DEATH BETHESDA	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOMESP. WIFE	12b. KIND OF BUSINESS OR INDUSTRY 41				
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE DISTRICT OF Columbia	13c CITY OR TOWN DISTRICT OF Columbia	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 3809 WARREN ST. N.W.				
14. FATHER'S NAME First Julius	Middle Benjamin	15 MOTHER'S MAIDEN NAME First EMELIE	Middle LOEB				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 17 INFORMANT	Address Allyn E. KILSHIMER - 271 Conn Ave N.W.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any which gave rise to immediate cause (a). stating the underlying cause 4221 (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of Left Kidney, Post op with Metastatic Disease. (Peritoneal)							
19a. DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from Sept 3, 1968 , to Oct 4, 1968 , that (I) (we) last saw the deceased alive on Oct 4, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						22c. DATE SIGNED 10/5/68	
22b. SIGNATURE Richard H. Edelbaum MD	DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) Richard H. Edelbaum MD	22e. ADDRESS 4700 Bradley Boulevard Ch Cl. Md.						
23c. BURIAL, CREMATION, REMOVAL (Specify) 10/6/68	23b. DATE 10/6/68	23c. NAME OF CEMETERY OR CREMATORIAL MT. Lebanon Cem.	23d. LOCATION (City or Town) Ellicottsville Md.	(County) Ellicottsville	(State) Md.		
24. FUNERAL DIRECTOR B. Dargatzky & Sons. 3501 14th St. N.W. WASH. D.C.	ADDRESS 3501 14th St. N.W. WASH. D.C.	25a. REC'D BY REGISTRAR DATE OCT 8 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

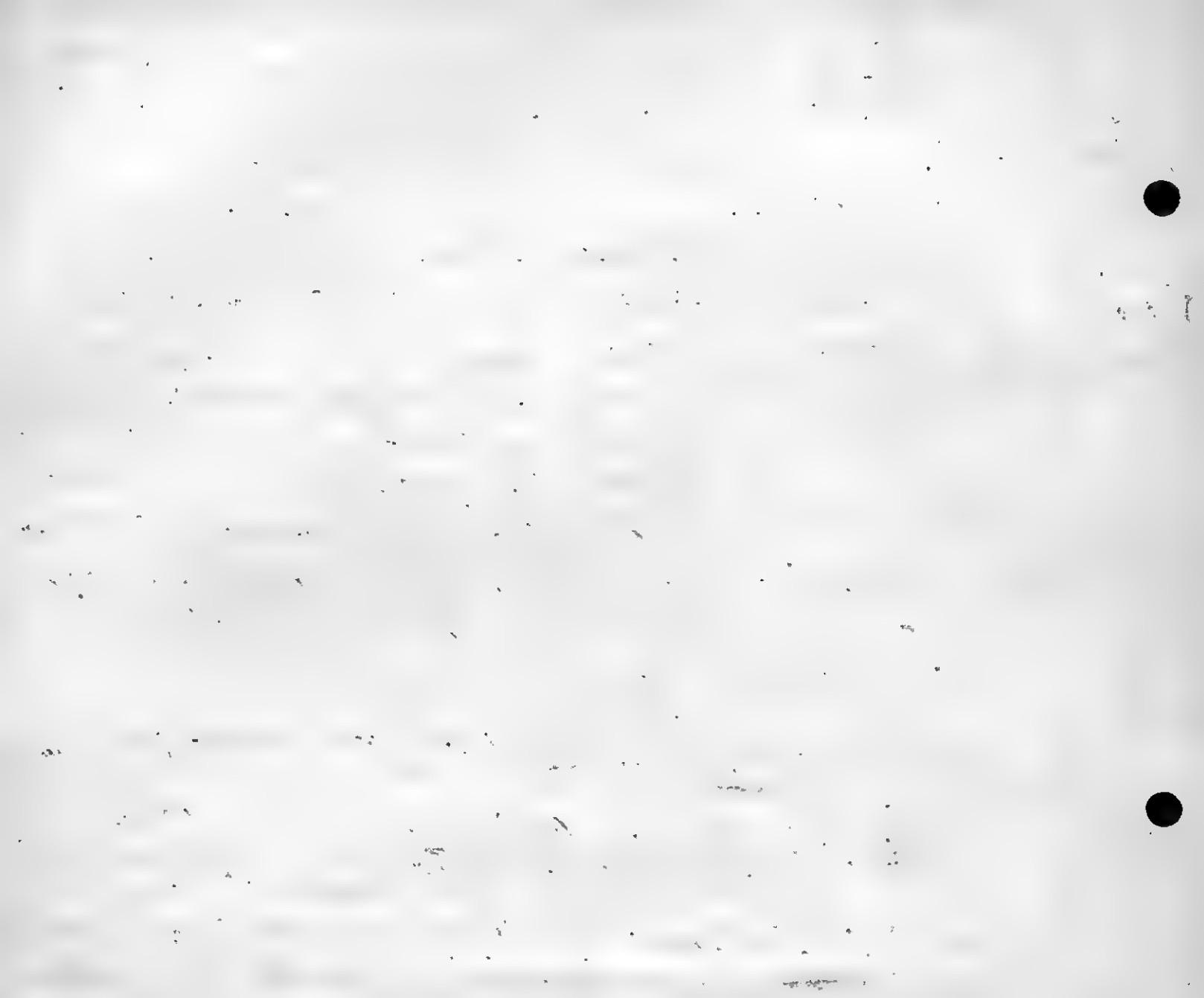
14680

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by medical examiner Dr. John Ball

1. DECEASED NAME (Type or print) <i>Mildred East</i>	Middle <i>S.</i>	Last <i>Kimball</i>	2a. DATE OF DEATH Month <i>Oct</i>	2b. HOURS <i>10A M</i>
3. SEX <i>Female</i>	4 RACE <i>Caucasian</i>	5. DATE OF BIRTH <i>12-19-1884</i>	6 AGE (In years last birthday) <i>83</i>	7. IF UNDER 24 HRS MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>New Hampshire U.S.A.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. Adelphi San. & Hosp.</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Pr. Georges</i>	13c. CITY OR TOWN <i>Adelphi</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>2503 Woodberry Street</i>
14. FATHER'S NAME First <i>Walter</i>	Middle <i>D.</i>	Last <i>Stevens</i>	15. MOTHER'S MAIDEN NAME First <i>Martha</i>	Middle <i>G.</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO <i>220-44-6928</i>	17. INFORMANT <i>Dorald Kirball</i>	Address <i>Adelphi, Md.</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>287.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Acute shock -</i>				14 days.
(b) DUE TO, OR AS A CONSEQUENCE OF <i>Acute Pancreatitis -</i>				2 weeks.
(c) DUE TO, OR AS A CONSEQUENCE OF <i>marked anemia -</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Thrombocytopenic purpura & multiple hemorrhages.</i>				
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES.</i>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING FACTOR OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>3 Oct 1968</i>		
21d. INJURY OCCURRED While <input type="checkbox"/> NOT WHILE <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC. <i>Office building</i>	21f. LOCATION Street or R.F.D. No. <i>3522 WESTERN AVE</i>	City or Town <i>CHEVY CHASE, Md.</i>	County <i>Prince George's</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>3 Oct 1968</i> , to <i>12 Oct 1968</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>11 Oct 1968</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.				
22b. SIGNATURE <i>J.H. Richwine M.D.</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>13 Oct 68</i>
22d. PHYSICIAN'S NAME (Type) <i>J.H. RICHWINE M.D.</i>	22e. ADDRESS <i>3522 WESTERN AVE</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10-16-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ht. Lincoln Cemetery</i>	23d. LOCATION (City or Town) <i>Prince George's</i>	(County) <i>Maryland</i>
24a. DIRECTOR <i>C. Glen Carter</i>	ADDRESS <i>Sil. Spr. Md.</i>	25a. REC'D BY REGISTRAR <i>Warren E. Pumphrey, Inc. 8434 Georgia Ave.</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE <i>OCT 21 1968</i>



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if my delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be rejoined for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14681

14673

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
<i>Norothy E. Kline</i>						10/12	19	68	10PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years or months)	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS. DAYS	9. IF UNDER 24 HRS. HOURS	10. IF UNDER 24 HRS. MIN				
FEMALE	W	Feb. 9-1926	75 yrs	10	15	15	15				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during period of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban Hospital			Housewife			Md.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland Montgomery			Bethesda		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5215 Frederick Ave				
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Harry P Shadley			Jessie Mae Fogel								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
(No give war or dates of service)			213-24842			William Glenn Frederick M.D.			120 W-5TH ST.		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
43 hr.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Aneurysm, basillar (congenital, Berry type) ruptured</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 310 X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John G. Ball</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Dr. John G. Ball M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED <u>Oct 14, 1968</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10-17-1968			23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Memorial Gardens			23d. LOCATION (City or Town) Frederick, Frederick, Md.		
24. FUNERAL DIRECTOR			ADDRESS Robert E. Dailey & Son			25a. REC'D BY REGISTRAR DATE OCT 16 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

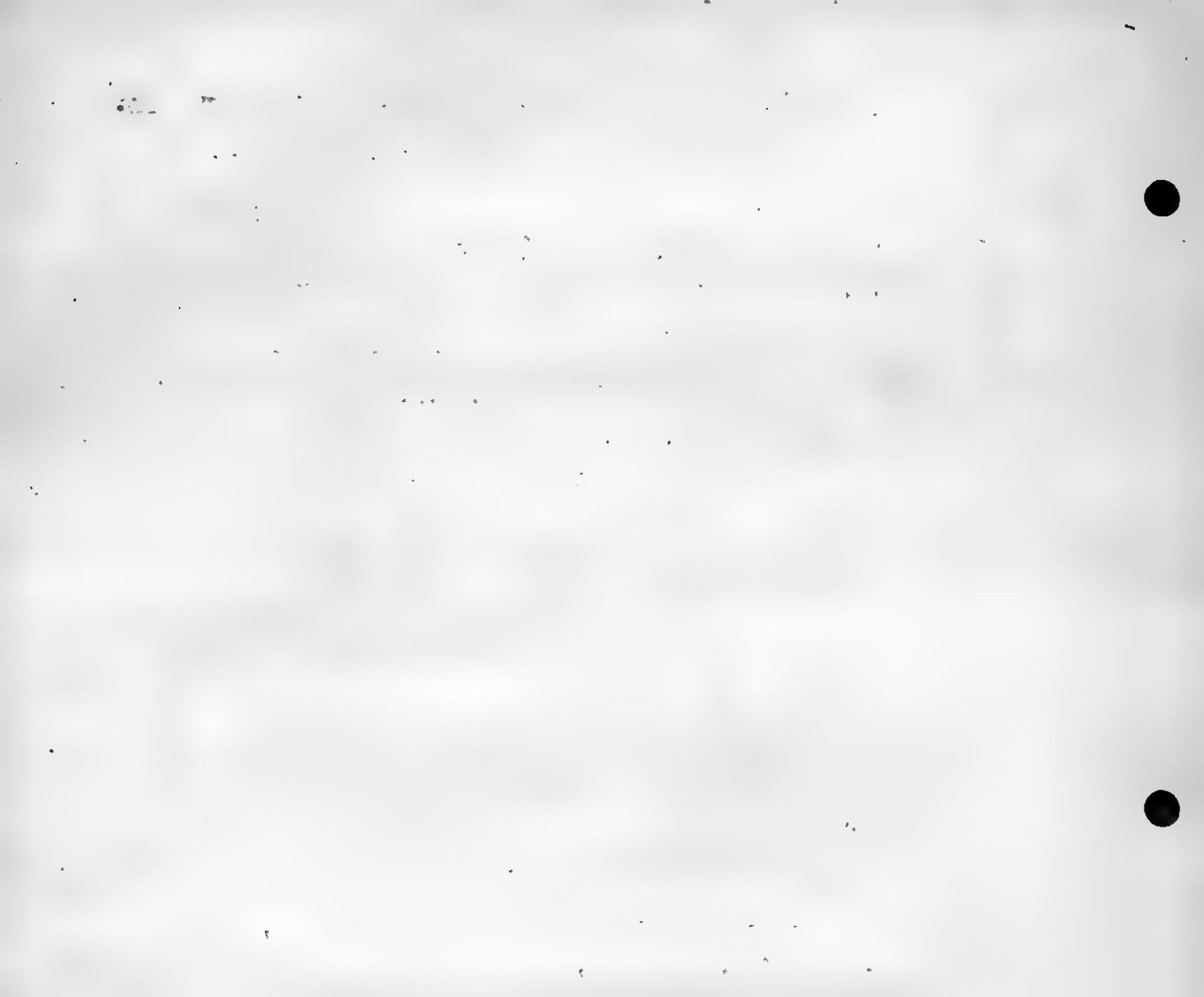
CERTIFICATE OF DEATH

14682

14676

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Caroline	Middle T.	Last Knickerbocker	2a. DATE OF DEATH Month 10 Day 1968 Year	2b. HOUR 5 10 M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 10/31/1877		6. AGE (in years lost birthday) 90 yrs.	
7a. BIRTHPLACE (State or foreign country) Maine	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Mont.	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY L.M.I.S.P. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 5016 Hampden Lane	12b. KIND OF BUSINESS OR INDUSTRY Marble
14. FATHER'S NAME Orlando	First Middle Thayer	15. MOTHER'S MAIDEN NAME Elizabeth M.	16. SOCIAL SECURITY NO 005-09-8961		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or <input checked="" type="checkbox"/> (If yes give war or dates of service) NO	17. INFORMANT Daughter Mrs. C.R. Harley		Address Same as Item 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min		
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive heart disease			10 years		
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
445X		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
MEDICAL CERTIFICATION		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>64</u> , to <u>Oct</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>24 Sept</u> , 19 <u>64</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Herbert Martyn Jr		MD DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) HERBERT MARTYN JR		22e. ADDRESS 4740 Chevy Chase Dr Chag		22c. DATE SIGNED 1 Oct 68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10- 6-68	23c. NAME OF CEMETERY OR CREMATORIAL Paris Hill Cemetery		23d. LOCATION (City or Town) Paris, Maine (County) (State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. RECD BY REGISTRAR DATE OCT 7 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14675

CERTIFICATE OF DEATH

14683

1. DECEASED NAME (Type or print) WILLIAM C. LANGE			First	Middle	Last	2a. DATE OF DEATH Oct. 17 1968	Month	Year	2b. HOUR 8:45A		
3. SEX Male	4. RACE White	S. DATE OF BIRTH April 17, 1885			6 AGE (In years last birthday) 83	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0			
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Ashville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Defiance Valley N. N.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) AUDITOR		12b. KIND OF BUSINESS OR INDUSTRY PRIV. IND.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY MONTG. BETHESDA		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 5008 EARLSTON DR.				
14. FATHER'S NAME First Friedrich		Middle	Last	15. MOTHER'S MAIDEN NAME First LANGE		Middle		Last Barz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 578 24 5197		17. INFORMANT DR. G. ROBERT LANGE-SON-Same As #13		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteritis sclerotic 440.9 (Conditions, if any, whch gave rise to immediate cause (a), stating the underlying cause last.)		DEU TO, OR AS A CONSEQUENCE OF (b) Pneumonia - Atelectasis		DEU TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years 3 day					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) TUB											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21b. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 8/25 , 19 67 , to 10/17 , 19 68 , that (I) (was) last saw the deceased alive on 10/15 , 19 68 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did) view the body after death.										22c. DATE SIGNED Oct 17, 1968	
22b. SIGNATURE HARRY N. CARLTON MD		22c. DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) HARRY N. CARLTON		22e. ADDRESS 8811 Colesville Rd, Silver Spring, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 10/19/68		23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CREMATORIAL		23d. LOCATION (City or Town) SUITLAND, MD.		(County)		(State)	
24. FUNERAL DIRECTOR SOS. GAWLER'S SONS, 5130 WIS. AVE, WASH. D.C.		ADDRESS		25a. REC'D. BY REGISTRAR OCT 23 1968		25b. REGISTRAR'S SIGNATURE Charles Juge					



FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with \$6.00. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14676 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14684

1. DECEASED-NAME (Type or Print)		XXXXXX		Last	2a DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Oct 3 1968 P.M.	2b HOUR
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years) last birth	7f UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year Oct. 4. 1968 12:55 P.M.	2d HOUR
M.	W.	3/7/1903	65 YRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 816 Easly St.		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Ship Analyst Retired		12b KIND OF BUSINESS OR INDUSTRY US Gov't.
13a USUAL RESIDENCE (Where deceased lived if institution admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 816 Easly St.
14 FATHER'S NAME First Clarence Middle A. Last Langley		15 MOTHER'S MAIDEN NAME First Carrie Middle Jane Last Downs				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIA. SEC. RITY NO. 217-42-4713		17. INFORMANT Silver Spring, ADD'L. Marguerite Langley 611 Ray Drive		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3321 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Hemorrhage. GastroIntestinal- Severe				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 70 min.
(b) DUE TO, OR AS A CONSEQUENCE OF		Rupture- of Duodenal Ulcer.				
(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic- Alcoholism -						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Oct 7, 1968		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Lincoln Cemetery		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		C. Glen Carter		23d. LOCATION (City or Town) (County) (State) Prince George County, Md.		
REMOVED		DRESS Gown		25a. REC'D BY REGISTRAR DATE OCT 10 1968		
10M REV				25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14685

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 10 AM
Miss Elizabeth Dalrymple hanning 10				8	1968
3. SEX	RACE	5. DATE OF BIRTH 12-30-1886	6. AGE (in years last birthday) 81 yrs.	7. IF UNDER 24 HRS. MONTHS	8. IF UNDER 24 HRS. DAYS
Female White					
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery County	Md.	
New Jersey		United States			
10. CITY OR TOWN OF DEATH Takoma Park	NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sand Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life even if not ready) Government Worker	
Maryland	13a. US/AL RESIDENCE (Where deceased lived, if institution: Res. dence Before admission) Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2504 Henderson Street
14. FATHER'S NAME Charles W. hanning	First	Middle	Last	15. MOTHER'S MAIDEN NAME Belle Dalrymple	16. APPROXIMATE INTERVAL BETWEEN BIRTH AND DEATH 3 days
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No	16b. SOCIAL SECURITY NO.			17. INFORMANT Margaret C. Lamping Address 2504 Henderson St. Wheaton	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure 3 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) diabetes + generalized arteriosclerosis					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from 8/1/68, 19, to 10/8, 1968, that (I) (we) last saw the deceased alive on 10/7/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Patrick C. Jamison	DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10/8/68
22d. PHYSICIAN'S NAME (Type) Patrick C. Jamison	22e. ADDRESS 11718 Georgia Silver Spring				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-10-1968	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City or Town) Prince Georges, Maryland	(County)	(State)
24. FUNERAL DIRECTOR C. Glen Carter Warren E. Pumphrey, Inc.	ADDRESS Sil. Spr., Md.	25a. REC'D. BY REGISTRAR OCT 11 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14678

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14686

1. DECEASED NAME (Type or Print)			First <i>Theodore</i>	Middle <i>Paul</i>	Last <i>Lantz</i>	2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year DEATH ESTI- MATED <input type="checkbox"/> Oct 12 1968	2b HOUR 6:00 AM Md	
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>Jan. 2, 1879</i>	6 AGE (in years last birthday) <i>89 yrs</i>	7 IF UNDER 24 HRS MONTHS <i>0</i>	8 FEAR DAYS <i>0</i>	9 IF UNDER 24 HRS HOURS <i>0</i>	10 MIN. <i>0</i>	
7a BIRTHPLACE (State or foreign country) <i>Akron Ohio</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>		
10 CITY OR TOWN OF DEATH <i>Kensington</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kensington Gardens San.</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Goodrich Rubber, O</i>
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>			13c CITY OR TOWN <i>Takoma Park</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>7403 Cedar Ave.</i>		
14. FATHER'S NAME First <i>William</i>			Middle <i>Lantz</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Henrietta</i>		Middle <i>Sherbondy</i>	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b SOCIAL SECURITY NO (If yes give war or dates of service) <i>299-01-1857-A</i>		17 INFORMANT <i>7403 Cedar Ave.</i>	ADDRESS <i>Wm. H. Corp Takoma Park, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>Cardio-Vascular Disease.</i> Years. (b) <i>Generalized Atherosclerosis -</i> Years. (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a) <i>None</i>								
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) 21d LOCATION Street or R.F.D. No CITY or Town County State			
21e INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>Chatworth, California</i>				22b DATE SIGNED <i>Oct. 14, 1968</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b DATE <i>Oct. 17, 1968</i>		23c NAME OF CEMETERY OR CREMATORIAL <i>Oakwood Memorial Park</i>		23d LOCATE ON (City or Town) (County) (State) <i>Chatworth, California</i>	
24. FUNERAL DIRECTOR <i>Robert Carter Warner E. Humphrey, Inc.</i>			24b ADDRESS <i>1016 East, Maryland 8434 Ga. Ave., Silver Spring</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 21 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14687

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies pages 1 and 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>Fredric P Lee</i>	Middle <i>P</i>	Last <i>Lee</i>	2a DATE OF DEATH Month <i>Oct</i>	Day <i>28</i>	Year <i>1968</i>	2b HOUR <i>11:00 AM</i>
3 SEX <i>m.</i>	4 RACE <i>w</i>	S. DATE OF BIRTH <i>11/6/93</i>	6 AGE (In years last birthday) <i>25</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	HOURS <i>0</i>	MIN <i>0</i>
7a BIRTHPLACE (State or Foreign Country) <i>Nebraska</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>				
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bethesda</i>	12a. usual OCCUPATION (Kind of work done during last of working if even if retired) <i>Teacher</i>	12b KIND OF BUSINESS OR INDSTRY <i>Montgomery Woods Food</i>				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>	13b. CITY OR TOWN <i>Montgomery Bethesda</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>7401 Windsor Road</i>				
14. FATHER'S NAME First <i>George Lee</i>	Middle <i></i>	Last <i></i>	15 MOTHER'S MAIDEN NAME First <i>Maudie Paddock</i>	Middle <i></i>	Last <i></i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	16b SOCIAL SECURITY NO <i>401-09-0523</i>	17 INFORMANT <i>Mrs. Marion Lee</i>	Address <i>Same as above</i>				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarct</i> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary arterial sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 420							
19a. MEDICAL CERTIFICATE ON DATE OF OPERATION <i>4/20/68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State	
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>Sept. 26 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>Alban W. Eger</i>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>Oct. 2, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>Alban W. Eger, M.D.</i>	22e. ADDRESS <i>1801 Eye street, N.W., Washington, D.C.</i>						
23a. BURIA, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE <i>10-4-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>	23d. LOCATION (City or Town) <i>Suitland, Maryland</i>	(County) (State)			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	ADDRESS <i></i>	25a. REC'D BY REGISTRAR DATE <i>OCT 7 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14680

14688

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Homer	Middle David	Last Liebersohn	2a. DATE OF DEATH Month October	Day 7	Year 1968	2b. HOUR A.M. 5:30
3. SEX Male	4 RACE White	5. DATE OF BIRTH June 12, 1913		6. AGE (In years last birthday) 55		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Store Keeper		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3231 Coquelin Terrace			
14. FATHER'S NAME First Joseph	Middle Liebersohn	Last 	15. MOTHER'S MAIDEN NAME First Yetta	Middle 	Last Margolis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 579-24-6898	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma of Liver (Widespread)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Years
17.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
		21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (s) (this hospital) attended the deceased from October 5, 1968 , to October 7, 1968 , that (s) (we) last saw the deceased alive on October 1, 1968 , and that in (s) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Robert E. Curran MD</i>		ATTENDING PHYS. DEGREE	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 7 October 1968		
22d. PHYSICIAN'S NAME (Type) Robert E. Curran, MD.	22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-9-1968	23c. NAME OF CEMETERY OR CREMATORIAL National Memorial Park		23d. LOCATION (City or Town) Falls Church		(County) Va.	(State)
24. FUNERAL DIRECTOR <i>Grocery Funeral Home 4217 9th & St. N.W.</i>	ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 9 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

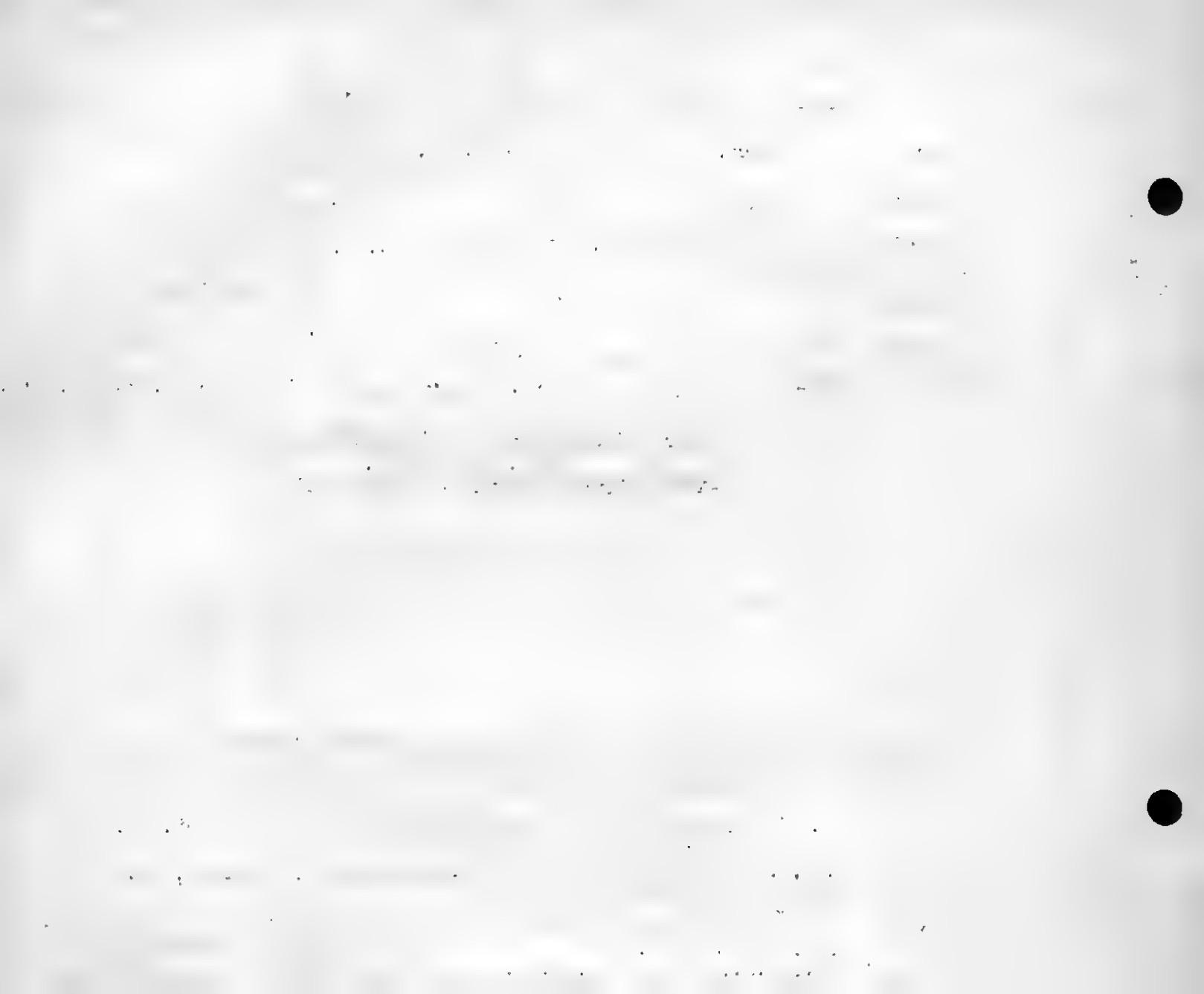
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14689

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First Michael	Middle Dennis	Last LIGINO	2a. DATE OF DEATH OCTOBER	Month 17	Day Year 17 68	2b. HOUR 620PM		
3. SEX Male		4 RACE Caucasian		5. DATE OF BIRTH Jan. 27, 1945		6. AGE (in years last birthday) 23		IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during last 6 months, even if retired) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY Md.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Illinois		13c. CITY OR TOWN Moline		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1349 19th Street					
14. FATHER'S NAME Michael Ligino			15. MOTHER'S MAIDEN NAME Mary			16. SOCIAL SECURITY NO. 1964-1968			17. INFORMANT Mr. Michael Ligino, 1349 19th St. Moline, Ill.		
Address											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) EMBRYONAL CARCINOMA OF THE TESTES WITH WIDE SPREAD METASTASIS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause XANTHOGENIC ACUTE PERITONITIS											
DUE TO, OR AS A CONSEQUENCE OF (b) XANTHOGENIC ACUTE PERITONITIS											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that ✓ (this hospital) attended the deceased from April 17 , 19 68 , to October 17 , 19 68 , that ✓ (we) last saw the deceased alive on October 17 , 19 68 , and that in ✓ (our) opinion death occurred on the date and hour and from the causes stated above, ✓ (we) (did) ✓ (not) view the body after death.											
22b. SIGNATURE <i>R. N. Hood</i>		DEGREE ATTENDING PHYS		MED. DIRECTOR		STAFF PHYS		22c. DATE SIGNED Oct. 18, 1968			
22d. PHYSICIAN'S NAME (Type) LCDR R.N. HOOD MC USN		22e. ADDRESS Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 18 OCT 68		23c. NAME OF CEMETERY OR CREMATORIUM Moline Riverside Cemetery		23d. LOCATION (City or Town) Moline		(County) Ill.		(State)	
24. FUNERAL DIRECTOR W. W. Chambers Co. 1400 Chapin St., N.W., Washington, D.C.		ADDRESS		25a. REC'D BY REGISTRAR OCT 22 1968		25b. PLEADING JUDGE W. W. Chambers W. W. Chambers					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

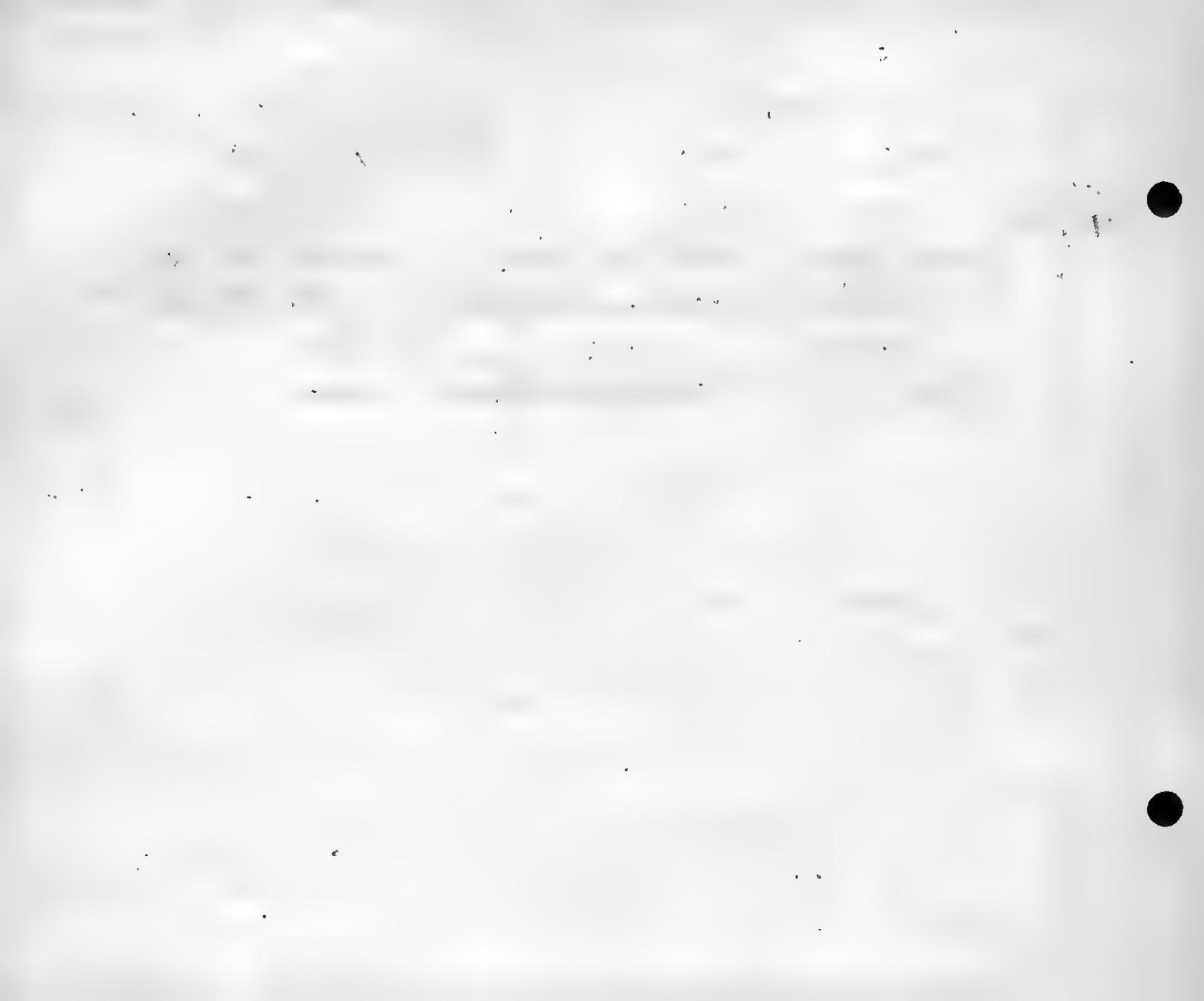
CERTIFICATE OF DEATH

14690

1 DECEASED NAME (Type or print)		First HYMAN	Middle	Lost	2a. DATE OF DEATH
3 SEX	4 RACE	S. DATE OF BIRTH	Month 10	Day 16	Year 68
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	
Poland		Amer.	Montgomery		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
Takoma Park		Wash. San + Hosp.		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER
Md.		Montgomery	Silver Spg.	4210 Harvard St.	
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First Middle Lost
Victor		Link		Rachel ?	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (<input type="checkbox"/> yes give war or dates of service)		16b SOCIAL SECURITY NO	17 INFORMANT	Address	
no		579-46-0311	Patient's chart		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardi al FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) ARTEROSCLEROTIC CARDIOVASCULAR DISEASE 5 years					
DUE TO, OR AS A CONSEQUENCE OF last (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) DIABETES MELLITUS					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>June, 1964</u> , to <u>Oct 16, 1968</u> , that (I) (we) last saw the deceased alive on <u>OCT. 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE	ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/> DATE SIGNED <u>OCT-16 1968</u>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		7733 ALASKA AVENUE NW. WASHINGTON D.C. 20012	
23a BURIAL, CREMATON, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORIAL	23d LOCATION (City or Town)		(County) (State)
BURIAL	10-18-1968	NATIONAL MEMORIAL PARK FALLS CHURCH	FALLS CHURCH		VA.
24 FUNERAL DIRECTOR	ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
GODINGER FUNERAL HOME 4217 9TH ST N.W.			DATE OCT 21 1968	Charles J. George	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Postage 2 and the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm 1 PIN 3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTL. DEATH MATED	Month	Day	Year	2b HOUR 9 13 P.M.		
MEREDITH			J.	LINNANE		10/20			1968			
3 SEX Male	4 RACE White	5 DATE OF BIRTH 4/4/1911	6 AGE (In years from birthday) 57	7f UNDER 1 YEAR MONTHS YRS	7f UNDER 24 HRS DAYS HOURS MIN	2c DATE PRONONCED DEAD Month 10 - 20	Year	1968	2d HOUR 9 13 P.M.			
7a BIRTHPLACE (State or foreign country) Bos. U.S.A.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery						
10 CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter			12b KIND OF BUSINESS OR INDUSTRY Contracting			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c CITY OR TOWN Montgomery		13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Silver Spring			4521 Bennion Rd.			
14 FATHER'S NAME Joseph			Middle	Lost	15 MOTHER'S MAIDEN NAME Patrick Linnane	Estella	Middle	Lost	Bostick			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) No		16b SOCIAL SECURITY NO. Un'known		17 INFORMANT L. B. Beldon		ADDRESS 4521 Bennion Rd. Silver Spring Md.						
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Acute Coronary Insufficiency Due to, or as a consequence of (c) Coronary Artery Heart Disease</p>												
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>												
<p>19a DATE OF OPERATION 4/10/1</p>												
19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>												
<p>ACTUAL SIGNATURE <i>Belden R. Keap</i></p>												
<p>EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.</p>												
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 10-23-1968		23c NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery		23d LOCATION (City or Town) Sil. Spr. Montgomery Md.		(County)			(State)	
24. FUNERAL DIRECTOR Glen Carter Cullen Clegg		ADDRESS 8424 Ga. Ave.		25a REC'D BY REGISTRAR DATE OCT 25 1968		25b REGISTRAR'S SIGNATURE Charles Judge						
<p>VR A15ME (5) TOM REV 1/68</p>												



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

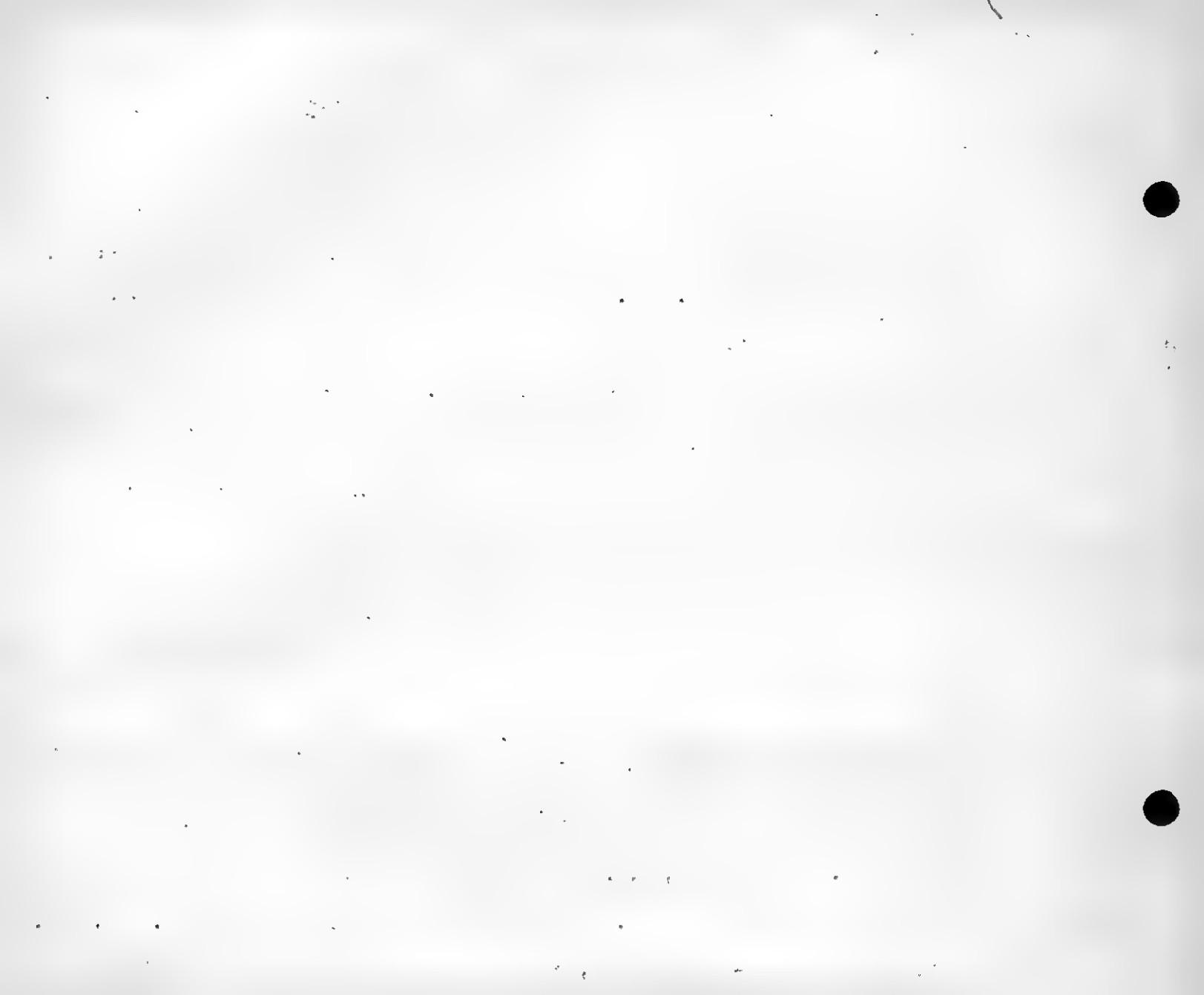
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14684

14692

1. DECEASED-NAME (Type or print)		First <i>Lillian</i>	Middle <i>N</i>	Last <i>Lively</i>	2a. DATE OF DEATH Month <i>Oct.</i>	Day <i>26</i>	Year <i>1968</i>	2b. HOUR <i>12 PM</i>					
3. SEX <i>Female</i>		4 RACE <i>white</i>	5 DATE OF BIRTH <i>12/02/24</i>		6 AGE (in years last birthday) <i>46 yrs.</i>		IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 24 HRS HOURS <i>0</i>		MIN. <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>Kansas</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery County</i>							
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired.) <i>Staff</i>		12b. KIND OF BUSINESS OR IND. ISTRY. <i>US Gov't.</i>							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>		13c. CITY OR TOWN <i>Lanham</i>		13d. INSIDE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>		13e. STREET AND NUMBER <i>9311 Sheridan St.</i>							
14. FATHER'S NAME First <i>Fred</i>		Middle <i>C.</i>	Last <i>Nienke</i>	15. MOTHER'S MAIDEN NAME First <i>Minnie</i>		Middle <i>Katzenmire</i>		Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>217-44-2321</i>		17. INFORMANT <i>Kellis E. Lively - same as # 13</i>		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heartic Failure</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>					
174X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. <i>Adenocarcinoma of Breast</i>								1 yr					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>110X</i>													
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <i>April 1, 1968</i> , to <i>Oct 26, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 25, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>G. Leonard Gold</i>								DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/26/68</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>Silver Spring, Maryland</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10-28-68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Cemetery</i>		23d. LOCATION (City or Town) <i>Colmar Manor</i>		(County) <i>Pr. Geo.</i>		(State) <i>Md.</i>			
24. FUNERAL DIRECTOR <i>F. Gasch's Sons - Hyattsville, Maryland</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>OCT 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



14685

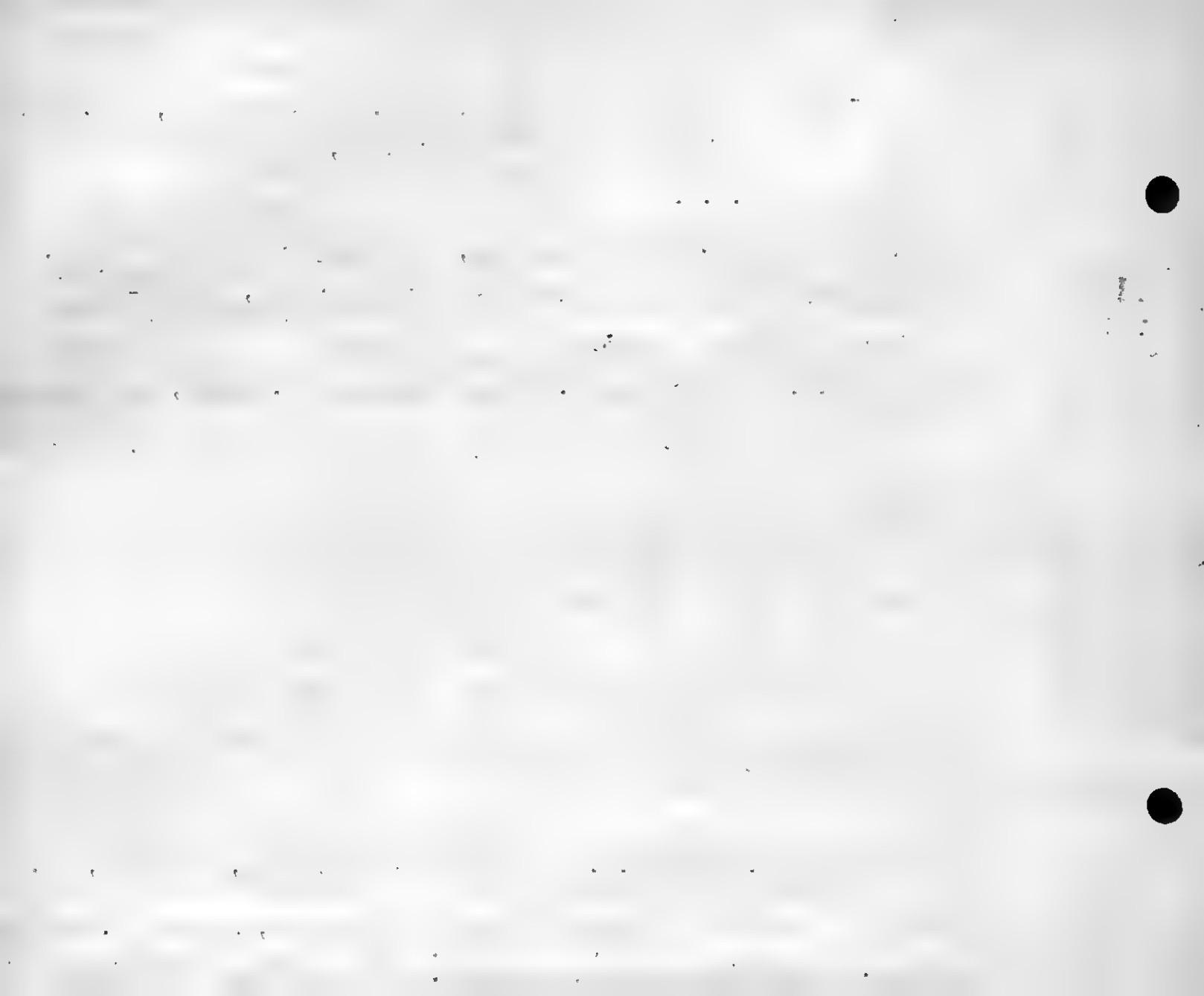
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14693

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	20. DATE OF DEATH Month	Day	Year	2b. HOUR P	
		EDGAR	RICE	LOCKE, SR.	October	8.	1968	5:15	
3. SEX		4. RACE	White	S. DATE OF BIRTH	6. AGE (in years Last birthday)				
Male				September 19, 1904	64	YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Colorado		U.S.A.					Montgomery		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Potomac		8204 Post Oak Road,			Manager			Oil Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		Camden Home	
Australia		Brisbane		Hamilton		Units, Unit 6-A			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			Kingsford Smith Drive.	
		Edgar	Rice	Locke	First			Walker	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Years or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
Yes		W.W. II		Not Avail. (Wife) Josephine S. Locke, Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic Cancer</i> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept.</i> , 1968, to <i>Sept.</i> , 1968, that (I) (we) last saw the deceased alive on <i>Sept.</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Jere J. Daum</i>									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			22c. DATE SIGNED 10/8/68				
JERE J. DAUM, M.D.		4977 Battery Lane, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City or Town)		(County)	(State)
Removal		10/9/68		Fairmount Cemetery		Denver		Denver Co.	Colorado
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE		-dc	
		7557 Wisconsin Ave.							
ROBERT A. PUMPHREY, Bethesda, Maryland				DATE OCT 11 1968		<i>Charles Juge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

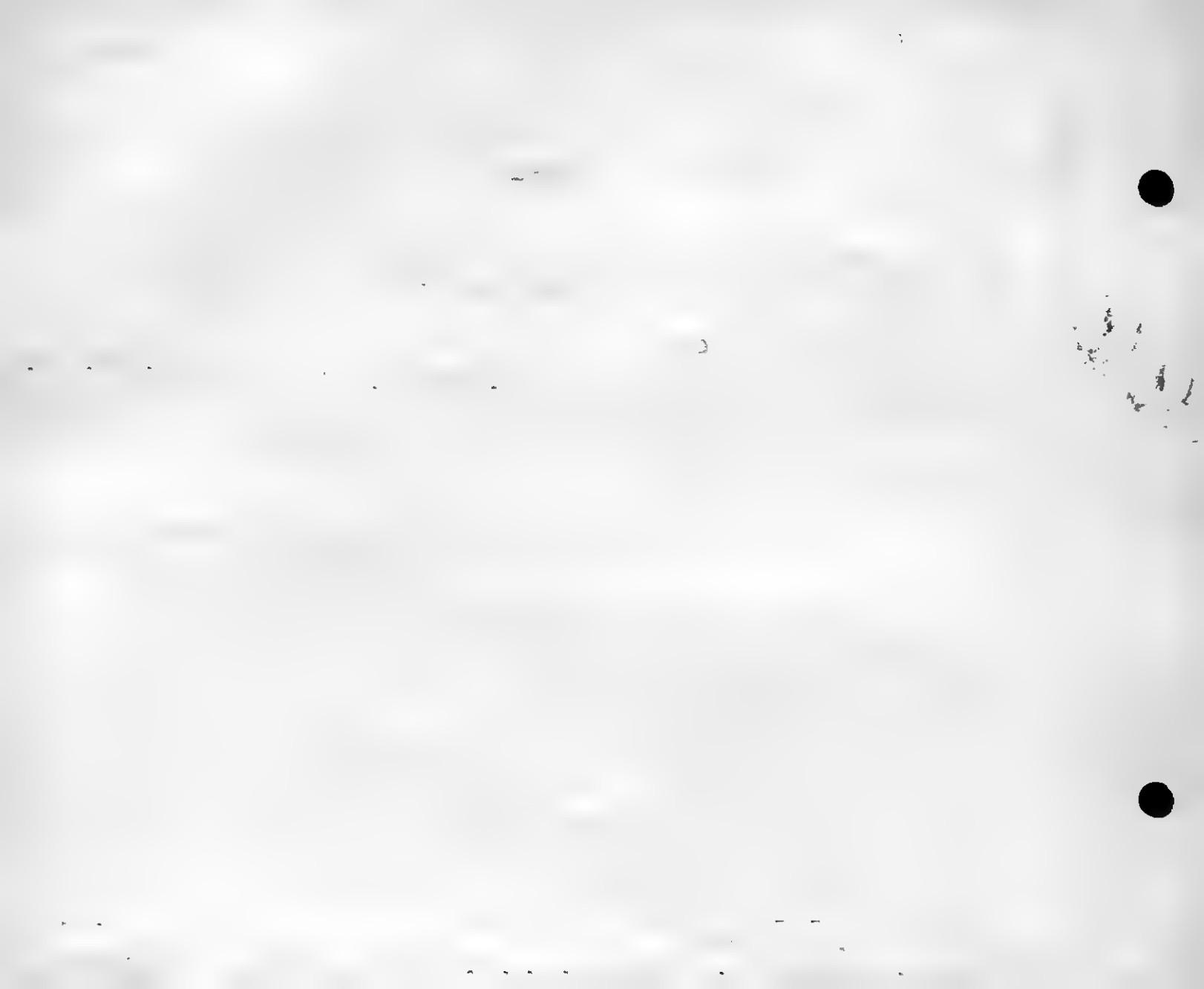
14654

1. DECEASED NAME (Type or print) MARGARET			First E.	Middle LOVELESS	Lost	2a. DATE OF DEATH Month 10	Day 12	Year 68	2b. HOUR 155 A.M.		
3. SEX FEMALE	4 RACE WHITE	S. DATE OF BIRTH 2-11-1868	6. AGE (In years last birthday) 100	IF UNDER 1 YEAR MONTHS 100	IF UND 24 HRS. HOURS 0	MIN 0					
7a. BIRTHPLACE (State or foreign country) Md 1880x	7b. CITIZEN OF WHAT COUNTRY? USA	B. <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH MONTGOMERY								
10 CITY OR TOWN OF DEATH SILVER SPRING Md.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospita give street address) FAIRLAND NURSING HOME	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME								
13a. USJA RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? NO	13e. STREET AND NUMBER 234 Dale Drive							
14. FATHER'S NAME JOHN A SOPER	MIDDLE 	LAST 	15. MOTHER'S MAIDEN NAME MARGARET E. CRAWFORD	MIDDLE 	LAST 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown 1	16b. SOCIAL SECURITY NO. 219-54-8234	17. INFORMANT Mrs. Bertha V. Quick	Address Sgt. Spr., Md.								
PART 1. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia, left lower lobe DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease						72 hrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						" "					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED Wh. <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFF CE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town		County	State					
22a. I certify that (I) (this hospital) attended the deceased from August 21 1968 , to October 12 1968 , that (I) (we) last saw the deceased alive on October 12 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Raymond Bradshaw, MD	DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED Oct. 12, 1968						
22d. PHYSICIAN'S NAME (Type) Raymond Bradshaw	22e. ADDRESS 345 University Blvd, W Silver Spring, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-15-1968	23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery	23d. LOCATION (City or Town) Washington	(County) D. C.							
GENERAL DIRECTOR C. Glen Carter			ADDRESS Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.	25a. REC'D BY REGISTRAR OCT 21 1968	25b. REGISTRAR'S SIGNATURE Charles Judge						

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician or by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14695

CERTIFICATE OF DEATH

14687

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Josephine	Middle F.	Last LOWE	2a DATE OF DEATH Month Oct. Day 13 Year 68	2b HOUR 848P M	
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH 2 May 1925		6 AGE (In years last birthday) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) Rhode Island	7b. CITIZEN OF WHAT COUNTRY? USA	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Registered nurse		12b KIND OF BUSINESS OR INDUSTRY Health	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia	13c. CITY OR TOWN Arlington	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 2943 S. Columbus Street			
14 FATHER'S NAME William M. McDermott	15. MOTHER'S MAIDEN NAME Margaret Quinlan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? + Yes, no, or unknown No	16b. SOCIAL SECURITY NO 030-18-8162	17 INFORMANT Arlington	Address Va.			
Mr. Kenneth R. Lowe, 2943 S. Columbus St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY.						
IMMEDIATE CAUSE (a) Carcinoma of breast with metastases to abdominal viscera						
DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> (b)						
DUE TO, OR AS A CONSEQUENCE OF						
(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar. 20 , 19 68 , to Oct. 13 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 13 , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.						
22b. SIGNATURE <i>D. L. Colgan</i> M.D.		DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED Oct. 14, 1968
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery Arlington		23d LOCATION (City or Town) Virginia	(County) (State)
24 FUNERAL DIRECTOR W. W. Chambers Co.		ADDRESS 8655 Georgia Ave., Silver Spring, Md.	25a. REC'D BY REGISTRAR DATE OCT 16 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



14688

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14696

1. DECEASED-NAME (Type or print)			First JAMES	Middle PRESTON	Last LYNN	2d. DATE OF DEATH Month 10 Day 17 Year 68	2b. HOUR 4:10 P.M.		
3. SEX MALE		4. RACE COLORED	5. DATE OF BIRTH 3/9/06			6. AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY UTILITIES		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SPENCERVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER BROGDEN ROAD			
14. FATHER'S NAME First JOSEPH		Middle L.	Last LYNN	15. MOTHER'S MAIDEN NAME First MARY		Middle L.	Last --		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT MEDICAL RECORDS		Address			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>4459 IMMEDIATE CAUSE (a) <i>Blood loss + Shock</i> DUE TO, OR AS A CONSEQUENCE OF <i>Hemorrhagic Gastritis</i> APPROXIMATE INTERVAL Conditions, if any, which gave 2 days. rise to immediate cause (a). stating the underlying cause last. 457x (b) 2-3 wks.</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>Multiple Pulmonary Infarcts. - Emboli - Thrombo phlebitis - Femoral</p>									
19a. DATE OF OPERATION 8-12-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Arterial Occlusion - Gangrene		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE, BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 7/24/68 , to 19 , that (I) (we) last saw the deceased alive on 10/17/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED 10/18/68
22b. SIGNATURE <i>Richard A. Yates M.D.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.					
22d. PHYSICIAN'S NAME (Type) RICHARD A. YATES, M.D.		22e. ADDRESS OLNEY, MARYLAND							
23d. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-22-68	23c. NAME OF CEMETERY OR CREMATORIAL ASH Memorial Cen.			23d. LOCATION (City or Town) Sandy Spring Montg. Md.		(County) Montgomery	(State) Md.
24. FUNERAL DIRECTOR <i>Robert L Snowden Rockville Md.</i>		ADDRESS <i>Robert L Snowden Rockville Md.</i>		25a. RECD BY REGISTRAR DATE OCT 3 1968			25b. REGISTRAR'S SIGNATURE <i>Charles "sage"</i>		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a physician may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

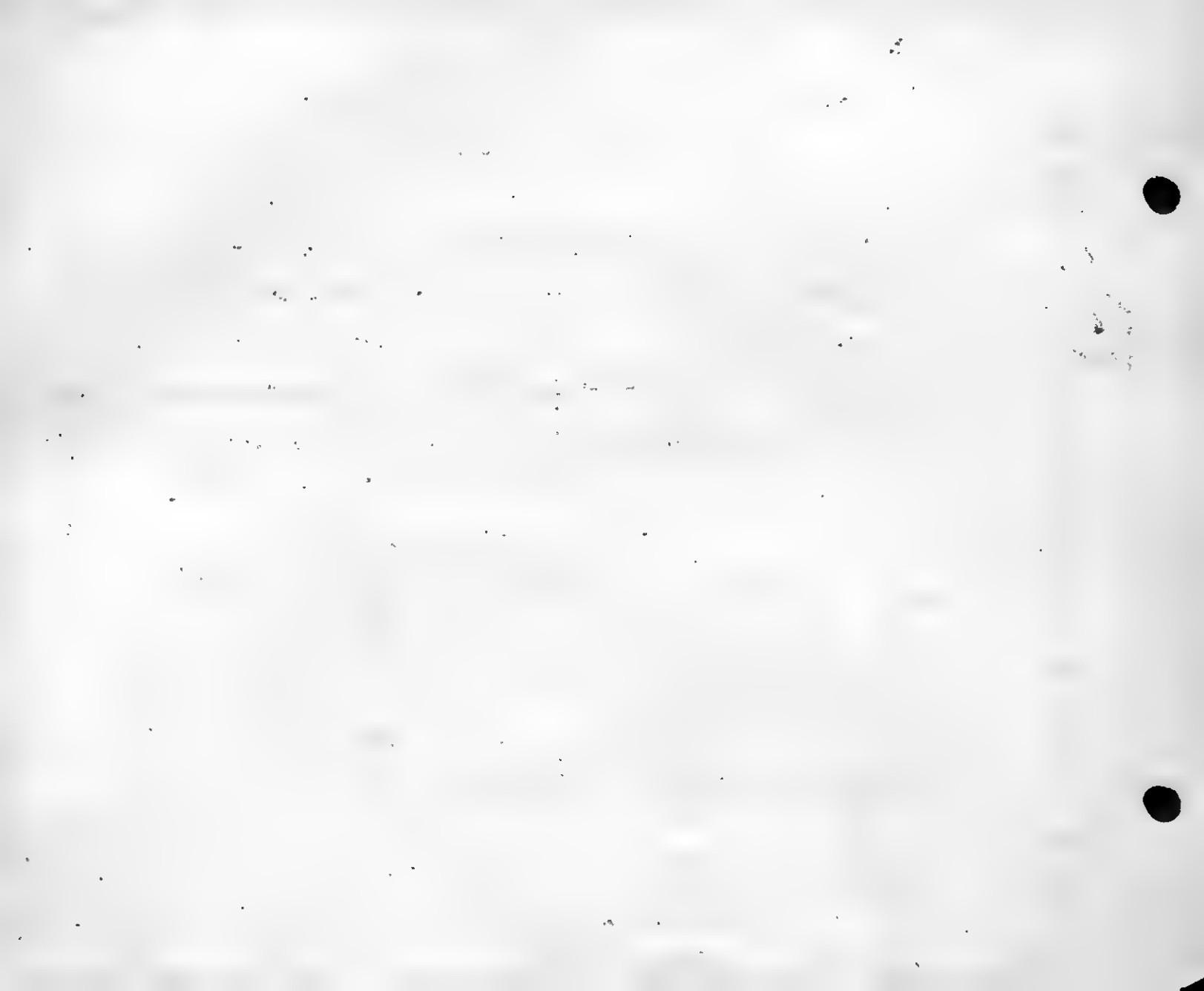
14697

14689

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print) Grace			Middle Mace	Lost	20. DATE OF DEATH Oct. 11 1968	2b. HOUR 3:30M
3. SEX female	4. RACE white	5. DATE OF BIRTH 6-7-1875			6. AGE (In years lost birthday) 93 yrs.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MN
7a. BIRTHPLACE (State or foreign country) Iowa	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa 12325 New Hamp. Ave., SS,			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Secretary		
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland	lived, if institution: Residence before 13b. COUNTY Mont.		13c. CITY OR TOWN Takoma Pk	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 704 Chaney Drive	12b. KIND OF BUSINESS OR INDUSTRY Church
14. FATHER'S NAME First John H. Durland	Middle	Lost	15. MOTHER'S MAIDEN NAME First Flora Runnels Durland	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 578-44-8032		17. INFORMANT Address Nursing Home Records, Colonial Villa			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 days DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>with cerebral hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>from his known Stay for last</i> 7 day						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>in tuberculosis & hypertension</i>						
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 10/7/68 , to 10/11/68 , that (I) (we) last saw the deceased alive on 10/7/68 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did-not) view the body after death						
22b. SIGNATURE <i>Howard T. Morse</i>						
22d. PHYSICIAN'S NAME (Type) Howard T. Morse M.D.	22e. ADDRESS 103 Carroll Ave - Takoma Park MD	22c. DATE SIGNED 10/11/68				
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE Oct 14, 1968	23c. NAME OF CEMETERY OR CREMATORIAL George Washington	23d. LOCATION (City or Town) Adelphi	(County)	(State)	
24. FUNERAL DIRECTOR Arthur Kesters, 254 Carroll St. N.W.	ADDRESS Arthur Kesters, 254 Carroll St. N.W.	25a. RECEIVED BY REGISTRAR DATE OCT 14 1968	25b. REGISTRAR'S SIGNATURE James J. Murphy			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14698

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 9:45 M	
Eunice M. Macuch					Oct	31	68		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		F UNDER 1 YEAR MONTHS DAYS HOURS MIN	
F		W		12/27/55		42 YRS		10 4	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
D.C.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Suburban		Sales Clerk					
13a. USUAL RESIDENCE (Where deceased lived, if institution addressee, STATE)		13b. CITY OR TOWN		13d. INSIDE CITY LIMIT?		13e. STREET AND NUMBER			
Montgomery Maryland		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1912 Stanley Ave			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Clayton				Hailey	Eunice M.		Oliver		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		220-12-3321		William Macuch.		Same as deceased			
18. CAUSE OF DEATH (Enter on one cause per line by (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		4509		Cerebral Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause				DUE TO, OR AS A CONSEQUENCE OF Berry Anemia					
(b)									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F. No.		City or Town		County	State
22a. I certify that (I) () hospital attended the deceased from saw the deceased alive on <u>10/31/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) () (do) (did) not view the body after death.				10/25/68		10/31/68			
22b. SIGNATURE		Robert C. Hailey		DEGREE	ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		ROBERT C. HAILEY		22e. ADDRESS		809 Viers Mill Rd, Rockville		10/31/68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/2/68		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn		23d. LOCATION (City or Town) Rockville, Maryland		(County) (State)	
24. FUNERAL DIRECTOR Tyson		ADDRESS The 1st 1331 Rockville Pike Rockville, Maryland 20852		25a. REC'D BY REGISTRAR NOV 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

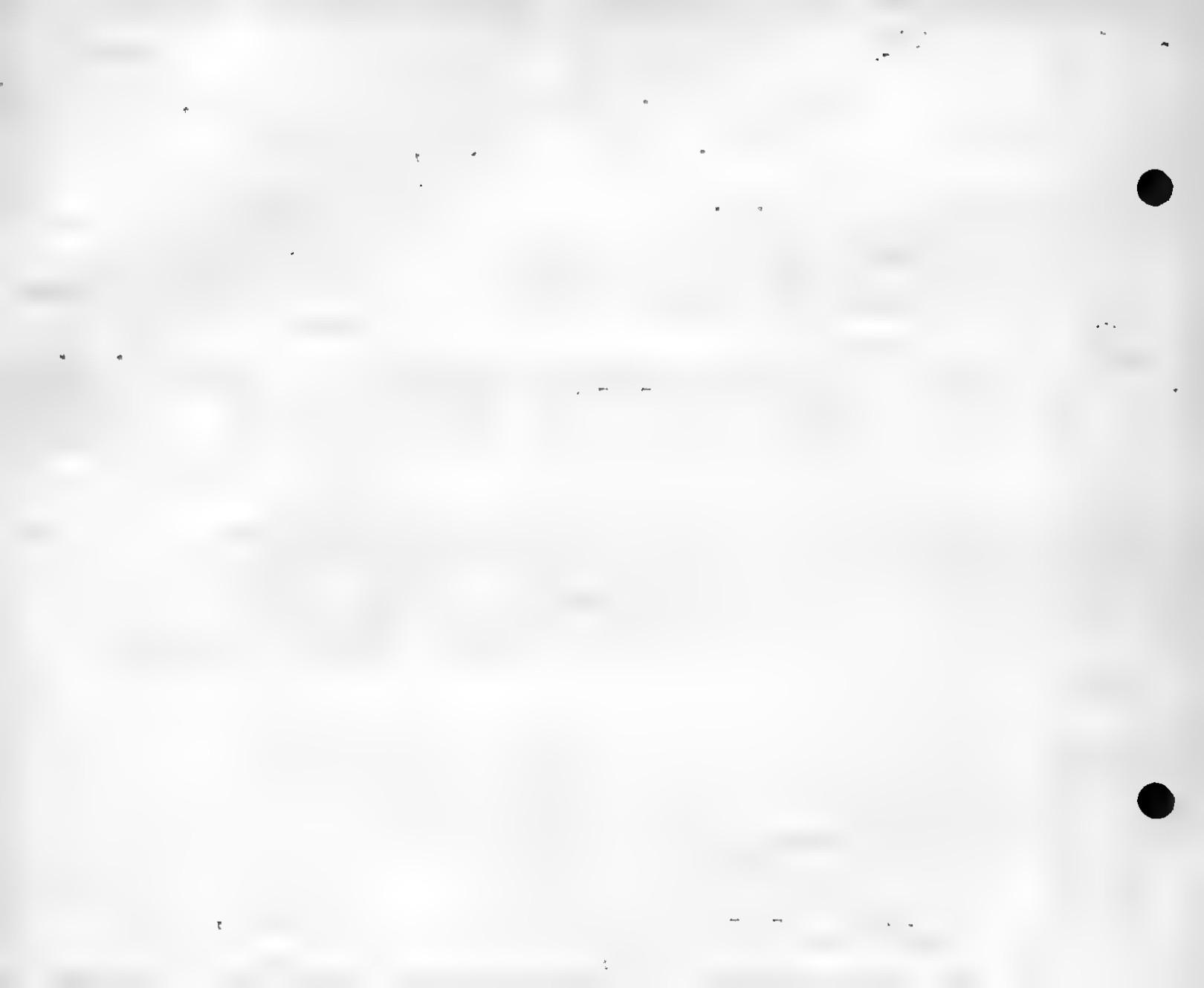
14699

1. DECEASED NAME (Type or print)	First FRANK	Middle E.	Last MADDOX	2a. DATE OF DEATH Month October	Day 12, 1968	Year 1968	2b. HOUR 6:10 M	
3. SEX Male	4 RACE Cauc.	5. DATE OF BIRTH Oct. 11, 1898		6. AGE (In years last birthday) 70	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grosvenor Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Fisherman			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Prince George	13c. CITY OR TOWN District Heights	13d. INSIDE CITY LIMITS YES	13e. STREET AND NUMBER 7108 Walker Mill Road				
14. FATHER'S NAME First Unknown	Middle W	Last W	15. MOTHER'S MAIDEN NAME First Unknown	Middle W	Last W	Address Wash. DC.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. (If yes give date of service) 220-12-3088	17. INFORMANT Ida Pearl Johnson	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH missed					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiovascular collapse DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) generalized carcinomatosis DUE TO, OR AS A CONSEQUENCE OF last (c) carcinoma of pancreas 4 months								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (This hospital) attended the deceased from 9/20/68 to 10/13/68 , that (I) (we) last saw the deceased alive on 10/11/68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Wilfred R. Efrantraut MD</i>		22c. DATE SIGNED 10/13/68						
22d. PHYSICIAN'S NAME (Type) <i>Wilfred R. Efrantraut</i>		22e. ADDRESS 1125 Rockville Pike						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-16-68	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	23d. LOCATION (City and State) Baltimore, Maryland				
24. FUNERAL DIRECTOR Robert A. Pumphrey		25a. REC'D BY REGISTRAR DATE OCT 18 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14700

14698

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>BERNARD</i>	Middle <i>F</i>	Last <i>MacGruder</i>	2a. DATE OF DEATH Month <i>10</i>	Doy <i>27</i>	Year <i>68</i>	2b. HOUR <i>9:30</i>	
3. SEX <i>Male</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>8-11-95</i>		6. AGE (in years last birthday) <i>73</i>	7. IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>MONTGOMERY</i>				
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>SUBURBAN</i>	12a. JSJAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Dir. of Eastern Rep. Board</i>		12b. KIND OF BUSINESS OR IND. STRY <i>Md.</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>	13b. COUNTY <i>MONTGOMERY</i>	13c. CITY OR TOWN <i>CHEVY CHASE</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>7306 Maple Avenue</i>				
14. FATHER'S NAME First <i>CHARLES</i>	Middle <i>MacGruder</i>	Last <i>Glenn</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Glenn</i>	Last <i>Reeves</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>Yes</i>	16b. SOCIAL SECURITY NO <i>316-10-7451</i>	17. INFORMANT <i>Marta C. MacGruder</i>	Address <i>same as above</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1621</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>PULMONARY RESECTION - BRONCHIO - PISTULA</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>2 MONTHS</i>								
19a. DATE OF OPERATION <i>10-14-68</i>	19b. CONDIT. ON FOR WHICH OPERATION WAS PERFORMED <i>BRONCHIAL CARCINOMA</i>	20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/>					
21a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>10-14-68</i> , to <i>10-27-68</i> , that (I) (was) last saw the deceased alive on <i>10-27-68</i> , and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d.d.) (did not) view the body after death.								
22b. SIGNATURE <i>J.W. Peabody Jr. MD</i>								
22d. PHYSICIAN'S NAME (Type) <i>J.W. PEABODY JR. MD</i>	22e. ADDRESS <i>1234 19th ST. N.W. WASH. D.C.</i>	22f. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22g. DATE SIGNED <i>10-27-68</i>					
23a. BURIAL, CREMATION, REMOVAL (Type) <i>Burial</i>	23b. DATE <i>10-30-68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Baltimore National</i>	23d. LOCATION (City or Town) <i>Baltimore Maryland</i>	(County) <i>Maryland</i>	(State) <i></i>			
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>	ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



14693 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 1/6/69 kk 14701

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)		First	Middle	Lost	20. DATE KNOWN OF ESTI- DEATH MADE		Month	Day	Year	2b. HOUR	
		RUSSELL	JOSEPH	MALONY	<input checked="" type="checkbox"/>	10	19	1968	P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 HRS DAYS		9. DATE PRONOUNCED DEAD Month		10d. HOUR
Male	White	DEC. 17 1919		48	YRS.		HRS.		October 23, 1968		8:15 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		9. COUNTY OF DEATH			
IOWA		USA		<input checked="" type="checkbox"/>		<input type="checkbox"/>		MONTGOMERY			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Gaithersburg			RFD #2 Box 202			MAILED			HOTEL		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Md.		Montgomery		Gaithersburg YES <input type="checkbox"/> NO <input type="checkbox"/>		RFD #2 Box 202					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
RUSSELL		m	Malony	Malony	JOSEPHINE				STEIL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
YES		506 09 3828		Maloney Malony ADDRESS							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 4129 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) 4221											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)								October 24, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) (County) (State)					
REMOVAL		OCT. 25 1968		PITTSFIELD VILLAGE		PITTSFIELD		MAINE			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REG STRARS SIGNATURE			
Francis H. Barber		Laytonville, Md.				OCT 28 1968		jCharles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14702

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)	First SALVATORE	Middle	Last MANCARI	2a. DATE OF DEATH Month OCTOBER	Day 8	Year 1968	2b. HO HR PM NOON
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH 11-4-1898	6. AGE (in years last birthday) 67 yrs.	IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0	
7a. BIRTHPLACE (State or foreign country) SCILIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH MONTGOMERY				
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN HOSPITAL	12a. US-JA OCCUPATION (Kind of work done during most of working life, even if retired) Kennedy's		12b. KIND OF BUSINESS OR INDUSTRY			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE DISTRICT OF COLUMBIA	13b. COUNTY Columbia	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMIT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 4611 ABERDEEN PL. WASHINGTON, D.C.			
14. FATHER'S NAME First JOSEPH	Middle	Last MANCARI	15. MOTHER'S MAIDEN NAME First ROSE UNKNOWN	Middle	Last LAVIDAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) NO	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 577-48-038	17. INFORMANT Herman	Address				
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Acute myocardial infarction						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one hour	
(b) Arteriosclerotic Cardiovascular Disease							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from June , 19 68 , to Oct 8 , 19 68 , that (I) (we) last saw the deceased alive on Oct 8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DeWitt E. DeLawter MD	DEGREE <input checked="" type="checkbox"/> MED DIRECTOR	ATTENDING PHYS.	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Oct 8, 1968			
22d. PHYSICIAN'S NAME (Type) DeWitt E. DeLawter	22e. ADDRESS 3848 Porter St. NW Wash D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-12-1968	23c. NAME OF CEMETERY OR CREMATORIAL ST. MARY'S CEMETERY	23d. LOCATION (City or Town) WASHINGTON D.C.	(County)	(State)		
24. FUNERAL DIRECTOR Robert A. DeSalvo	24b. FUNERAL ADDRESS DeSalvo Funeral Home	25a. REC'D BY REGISTRAR OCT 16 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

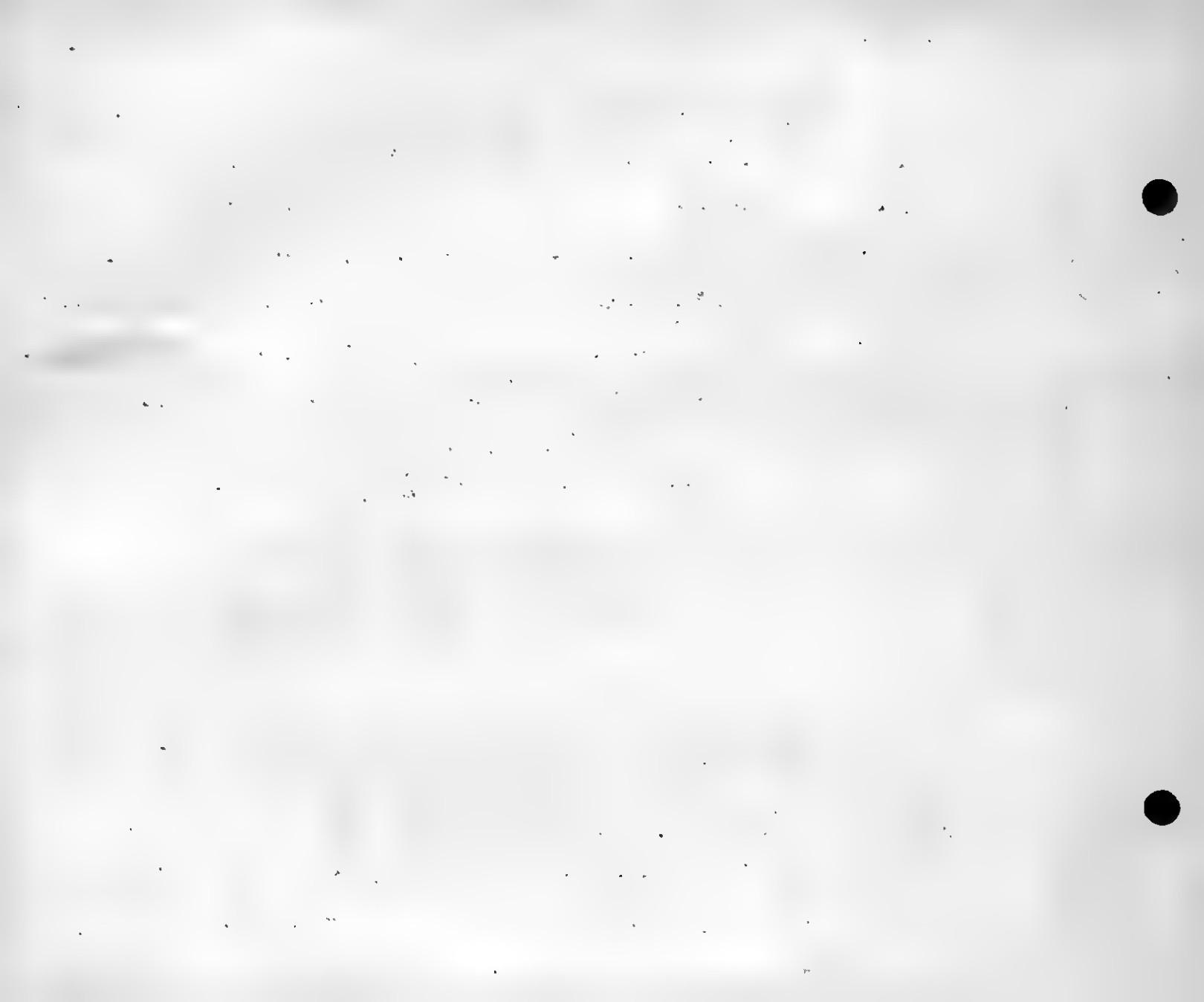
14703

14695

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 1f. UNDER 1 YEAR MONTHS	1f. UNDER 24 HRS HOURS	1f. UNDER 24 HRS MIN.
<i>Edgar Mason</i>					Oct	4	1968	1254A		
3. SEX <i>Male</i>		4 RACE <i>Caucasian</i>	5. DATE OF BIRTH <i>1-21-1883</i>		6 AGE (In years last birthday) <i>85 yrs.</i>		F UNDER 1 YEAR MONTHS	F UNDER 24 HRS HOURS	F UNDER 24 HRS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>America</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Montgomery</i>		Md.			
10. CITY OR TOWN OF DEATH <i>Kensington, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kensington Gardens Sanitarium & Extended Care Center</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Worker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Shipping Clerk</i>			
13a. JUSICAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Maryland</i>	13c. CITY OR TOWN <i>Kensington, Md.</i>		13d. INSIDE CITY, J.M. TSP? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>6616 Westmont Ave</i>				
14. FATHER'S NAME <i>H. L. Mason</i>		First	Middle	Last	15. MOTHER'S MAIDEN NAME <i>Nancy Frank</i>	Middle	1st			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <i>No</i>		16b. SOCIAL SECURITY NO. <i>224-10-9971A</i>		17. INFORMANT <i>Harold Mason - Relative</i>		Address <i>1027 1/2</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)										
MEDICAL CERTIFICATION		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
							<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1968</i> , to <i>Oct 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 3 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Bernard A. Fitzgerald</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10-4-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>		22e. ADDRESS <i>217 Union Blvd East Silver Spring Md</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>		23b. DATE <i>10-7-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>MT. HERMON</i>		23d. LOCATION (City or Town) <i>WINCHESTER</i>		(County) <i>VIRGINIA</i>	(State)		
24. FUNERAL DIRECTOR <i>Jeanne H. Fleming</i>		ADDRESS <i>Winchester, Va.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
				DATE <i>OCT 9 1968</i>						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14704

14696

Joan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR AM PM
JOAN		L	Maume	October 12 - 68	4:50 PM
3. SEX	4. RACE	5. DATE OF BIRTH 7/4/32		6. AGE (in years last birthday) 36 YRS.	
Female	White			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery	Md.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Area Sales Rep.	12b. KIND OF BUSINESS OR INDSTRY Hosery Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. CITY OR TOWN Pr. Geo.	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMIT YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3507 Maleek Lane	
14. FATHER'S NAME Robert	First Middle J.	Last Lowery	15. MOTHER'S MAIDEN NAME Doris	Middle Parker.	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 223-36-9854	17. INFORMANT John Maume	Address 3507 Maleek Lane, Bowie, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Acute Intestinal Pneumonia, Bilateral</u> 3/13 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hydrothorax, Bilateral</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <u>Pelvic Peritonitis; Renal Papillitis</u>					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Oct 7, 1968, to Oct 12, 1968, that (I) (we) last saw the deceased alive on Oct 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>BLAINE H. EITZINGER</u>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/12/1968		
22d. PHYSICIAN'S NAME (Type) BLAINE H. EITZINGER	22e. ADDRESS 9801 Georgia Court, Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10-16-1968	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery	23d. LOCATION (City or Town) Hampton, Virginia	(County)	(State)
24. FUNERAL DIRECTOR C. Glen Carter	ADDRESS Sil. Spr. Md.	25a. REC'D BY REGISTRAR DATE OCT 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	
Warren E. Pumphrey, Inc.	8434 Georgia Avenue				

1. 2. 3. 4. 5. 6. 7. 8. 9.

1. *H. tenuis* (L.) Benth.

2000-01-01 00:00:00 00000000000000000000000000000000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14697

14705

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 3:50 PM	
Catherine McCarty				OCT	13	1968		
3. SEX	4 RACE	S. DATE OF BIRTH	6 AGE (In years last birthday) 85 yrs		IF UNDER MONTHS	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	
Female	Caucasian	Feb 2 1883						
7. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		Montgomery			
England	U.S.A.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	115 Muncie Lane			Housewife		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	13c. CITY OR TOWN	3d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
STATE: MASS. COUNTY: Worcester County, Worcester, Mass.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7 Vassar St						
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
Patrick	Melvin			Mary	Julia	G. Taylor	Swift	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown. (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address					
No	013-26-7056	Julian G. Taylor	1115 Muncie Lane					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Cerebral Vascular Accident APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF BETWEEN ONSET AND DEATH 2 yrs								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Cerebral Arteriosclerosis 4 yrs								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from April, 1968, to Oct. 13, 1968, that (I) (we) last saw the deceased alive on Oct. 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE R.T. Benack		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/13/68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		4115 Colie Drive, Wheaton, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/16/68	23c. NAME OF CEMETERY OR CREMATORIAL St John's CEMETERY		23d. LOCATION (City or Town) Worcester		(County) Worcester	(State) Mass
24. FUNERAL DIRECTOR Warren E. Pumphrey, Inc., Silver Spring, Md.		ADDRESS 8434 Georgia Ave.	25a. RECEIVED BY REGISTRAR DATE OCT 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



14698

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14706

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Anna	Middle McClasky	Lost	2a. DATE OF DEATH Month 10 Day 29 Year 68	2b. HOUR 2:30 P.M.
3. SEX Female		4. RACE white	S. DATE OF BIRTH 9-2-93	6. AGE (In years last birthday) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		12b. KIND OF BUSINESS OR INDUSTRY Md.
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium + Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE Maryland		13b. COUNTY /	13c. CITY OR TOWN Derwood	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 7621 Wadler Lane	
14. FATHER'S NAME Patrick		Middle Prendergast	Lost	15. MOTHER'S MAIDEN NAME Bridget	Middle Battie	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO Unknown	17. INFORMANT Records - Washington Sanitarium + Hosp. +	Address		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident, acute, Recurrent 3 days</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Suspected Cerebral Hemorrhage 3 days</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cerebrovascular disease 3 years</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis, Chronic Cholelithiasis</u>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office, building etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 13, 1968</u> to <u>Oct 29, 1968</u> , that (II) (we) last saw the deceased alive on <u>Oct 28, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <u>Viewed by House Doctor</u>						
22b. SIGNATURE <u>John R. Spencer M.D.</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>10-29-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>John R. SPENCER</u>		22e. ADDRESS <u>BURTONSVILLE, MD.</u>				
23a. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE Sept 2-1968	23c. NAME OF CEMETERY OR CREMATORIAL FACILITY <u>Lawn Crest Cemetery, Linthicum, Md., Law.</u>		23d. LOCATION (CITY OR TOWN) (County) (State)	
24. FUNERAL DIRECTOR J. Arthur Wallace, 254 Carroll St. NW, Wash. D.C.		ADDRESS J. Arthur Wallace, 254 Carroll St. NW, Wash. D.C.	25a. RECD. BY REGISTRAR DATE NOV 1 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



12-18
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and carbon papers should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Charles Harry</i>	First AK1 - C. Harry McClaskey Middle <i>H. H. McClaskey</i> Last,	2a. DATE OF DEATH Month Day Year <i>October 14 1968</i>	2b. HOUR <i>8 1/2</i>
3. SEX <i>Male</i>	RACE <i>White</i>	S. DATE OF BIRTH <i>MARCH 1, 1892</i>	6. AGE (In years last birthday) <i>76 yrs</i>
7a. BIRTHPLACE (State or foreign country) <i>Philadelphia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>
10. CITY OR TOWN OF DEATH <i>Olney</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Brooke Grove Foundation</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Construction</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <i>Maryland</i>	13c. CITY OR TOWN <i>Montgomery</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>7621 Warbler Lane</i>
14. FATHER'S NAME First Middle Last <i>Charles H. McClaskey</i>	15. MOTHER'S MAIDEN NAME First Middle Last <i>Ellen Esther Jenkins</i>	Address <i>1400 Lee Line Rd., Lee Line, Mass. (daughter)</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>179-12-7502</i>	17. INFORMANT <i>Mrs. Patrick Trail, Longfellow Mass.</i>	Address <i>late</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetes</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteria</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis CV-Renal Disease</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>			
MEDICAL CERTIFICATION ON			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <i>7/25/68</i> to <i>10/14/68</i> , 1968, that (I) (we) last saw the deceased alive on <i>7/25/68</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <i>C.H. McClaskey, MD.</i>	DEGREE <i>MD.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <i>C.H. McClaskey, MD.</i>	22e. ADDRESS <i>Sandy Spring, Md.</i>	22f. DATE SIGNED <i>10/16/68</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>10/17/68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>AWN CROFT</i>	23d. LOCATION (City or Town) (County) (State) <i>Boothwyn Pa.</i>
24. FUNERAL DIRECTOR <i>PARR FUNERAL HOME</i>	ADDRESS <i>ES. MARY NAPLES 3-3220</i>	25a. REC'D BY REGISTRAR <i>DATE OCT 16 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MARYLAND STATE DEPARTMENT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14708

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be mailed within 24 hours of the physician's signature.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <i>David</i>	Middle <i>L</i>	Last <i>Mc Cutcheon</i>	2a. DATE OF DEATH Month <i>Oct</i>	Day <i>14</i>	Year <i>68</i>	2b. HOUR M <i>1700</i>	
3. SEX <i>Male</i>		4 RACE <i>W</i>	5. DATE OF BIRTH <i>May 26 1897</i>		6. AGE (In years last birthday) <i>71</i>		IF UNDER 1 YEAR MONTHS <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>Colo</i>		7b. CIT ZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		9. COUNTY OF DEATH <i>Montgomery</i>		IF UNDER 24 HRS. HOURS <i>0</i>	
10. CITY OR TOWN OF DEATH <i>Wheaton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Residence - Private Residence</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Painter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Painting</i>			
13a. US. RESIDENCE (Where deceased lived, if institution: Residence before outmigration) <i>10520 Ballue</i>		13c. CTY. OR TOWN <i>Montgomery</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>10820 Ballue Ave</i>			
14. FATHER'S NAME First <i>David</i>		Middle <i>McCutchen</i>	Last <i>Ella</i>	15. MOTHER'S MAIDEN NAME First <i>Mrs Rose Mc Cutchen</i>		Middle <i>McCutchen</i>	Last <i>Ella</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>4109</i>		17. INFORMANT <i>Mrs Rose Mc Cutchen</i>		Address <i>10820 Ballue Ave</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary arteriosclerosis</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral arteriosclerosis</i>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION <i>T-4-1</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>While at work</i>		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19 P.M. Oct 9 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>At home</i>		21f. LOCATION Street or R.F.D. No <i>10820 Ballue Ave</i>		City of Town <i>Wheaton</i>	County <i>Montgomery</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>MAY 1 1968</i> to <i>Oct 14 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 9 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Bennie H. Braden MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10-14-68</i>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>10820 Ballue Ave</i>							
23a. BURIAL/CREMATION, REMOVAL (Specify) <i>10/17/68</i>		23b. DATE <i>10/17/68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) <i>Wheaton</i>		(County) <i>Montgomery</i>	(State) <i>MD</i>	
24. FUNERAL DIRECTOR <i>John Hunterman & Son</i>		ADDRESS <i>5732 Ballue</i>	25a. REC'D. BY REGISTRAR DATE <i>OCT 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

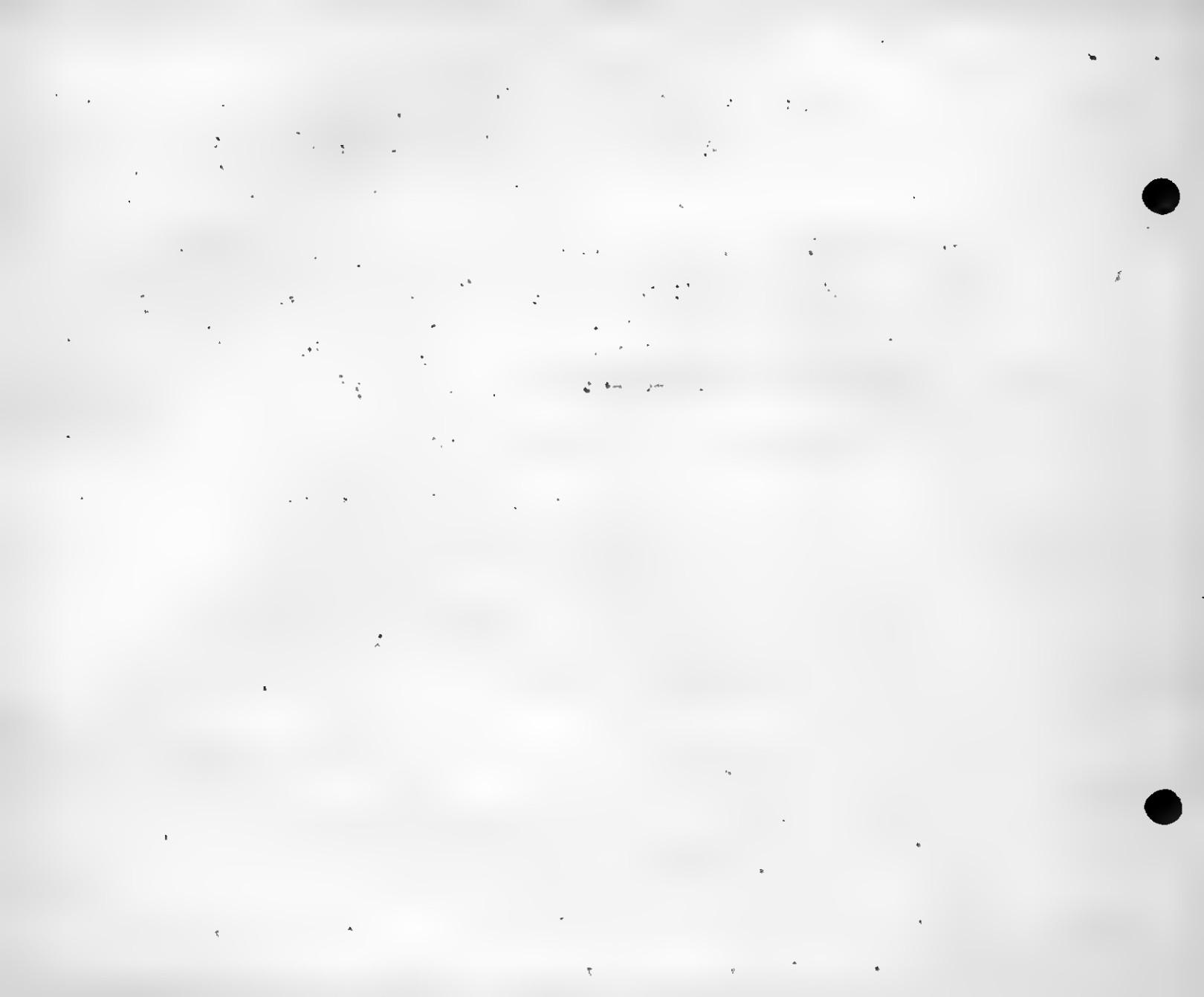
CERTIFICATE OF DEATH

14709

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Myrtle	Middle Ester	Last McGaha	2a. DATE OF DEATH Oct Month 14 Day Year Oct 14 1968	2b. HOUR 4:50 P.M.
3. SEX <input checked="" type="checkbox"/> F	4. RACE <input checked="" type="checkbox"/> W	5. DATE OF BIRTH Oct 27-1898		6. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <input checked="" type="checkbox"/> Md.	7b. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/> U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 916 Grandin Avenue	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md	13b. COUNTY Montgomery	13c. CITY OR TOWN Mont. Rockville	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 916 Grandin	
14. FATHER'S NAME First Harry	Middle —	Last Riley	15. MOTHER'S MAIDEN NAME First Rosie Bell	Middle Bean	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> No	16b. SOCIAL SECURITY NO. 217-405-9507B	17. INFORMANT Howard McGaha — Same	Address		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 101 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
(b) DUE TO, OR AS A CONSEQUENCE OF Lymphosarcoma			8 years		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At Home, Farm, Street, Factory Office Building, Etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Oct 1968, and that in (my) (his) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James W. Egan M.D.		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Oct 14-68
22d. PHYSICIAN'S NAME (Type) JAMES W. EGAN		22e. ADDRESS 5413 Cedar Lane-Bethesda			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-17-68	23c. NAME OF CEMETERY OR CREMATORIUM Rockville Cemetery	23d. LOCATION (City or Town) Rockville, Maryland	(County)	(State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland	ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland	25a. REC'D BY REGISTRAR OCT 21 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14710

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from Pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Joseph</i>	Middle <i>M</i>	Last <i>McMahon</i>	2a. DATE OF DEATH Month <i>10</i>	Day <i>17</i>	Year <i>1968</i>	2b. HOUR <i>11:54 AM</i>						
3. SEX <i>Male</i>	4. RACE <i>white</i>	S. DATE OF BIRTH <i>6/11/99</i>	6. AGE (In years lost birthday) <i>69</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	IF UNDER 24 HRS. MIN <i>0</i>						
7a BIRTHPLACE (State or foreign country) <i>New York</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery County Md.</i>										
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Contractor-Plumbing & Heating</i>	12b. KIND OF BUSINESS OR INDUSTRY										
13a USUAL RESIDENCE (Where deceased admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Kensington</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>10600 St. Paul Street</i>									
14. FATHER'S NAME First <i>John M. McMahon</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Mary King</i>	Middle <i></i>	Last								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b SOCIAL SECURITY NO (If yes give war or dates of service) <i>220-01-5717</i>	17. INFORMANT <i>Daughter Elizabeth McMahon</i>	Address <i>Same as Item 13.</i>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i> 472 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i>							
(b) DUE TO, OR AS A CONSEQUENCE OF <i>Cor pulmonale</i>													
(c) DUE TO, OR AS A CONSEQUENCE OF <i>(remote)</i>													
(d) <i>Left pneumonectomy with emphysema</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory Office, Building, Etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 15, 1968</i> , to <i>Oct 19, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 17, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Robert T. Thibadeau</i>		22c. DATE SIGNED <i>Oct 17, 1968</i>											
22d. PHYSICIAN'S NAME (Type) <i>ROBERT T. THIBADEAU</i>		22e. ADDRESS <i>11,000 OLD GEORGES TOWNSHIP RD. ROLLVILLE MD. 20852</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10-21-68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Andrews Chapel Cem.</i>		23d. LOCATION (City or Town) <i>Vienna, Virginia</i>		(County)		(State)			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>OCT 24 1968</i>		25b. REG. STAR'S SIGNATURE <i>Charles Judge</i>							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14711

1. DECEASED-NAME (Type or print) Elizabeth A. McKenna			First	Middle	Last	2a DATE OF DEATH Oct. Month 18 Day 1968	2b. HOUR 10:00
3. SEX Female	4. RACE White	5. DATE OF BIRTH Sept. 16 1889	6 AGE (In years last birthday) 79	7. IF UNDER 1 YEAR YRS.	8. IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6115 Wynnwood Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE N.Y.		13b. CITY OR TOWN New Rochelle		13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>	13e STREET AND NUMBER 142 Borair Ave.		
14 FATHER'S NAME First Theodore J Ellenbast		Middle	Last	15. MOTHER'S MAIDEN NAME First Catherine		Middle Last ?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Rita A Ferguson Daughter		Address #11	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY 342X IMMEDIATE CAUSE (a) Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Parkinson's disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 3 years 1 year					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJRY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 4/17, 1968, to 10/16, 1968, that (I) (we) last saw the deceased alive on 10/16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr Joseph P. Kenne		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/18/68		
22d. PHYSICIAN'S NAME (Type) Dr JOSEPH P. KENNE	22e. ADDRESS 6450 Wisconsin Ave, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/22/68	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cem.	23d. LOCATION (City or Town) Valhalla N.Y.	(County)	(State)		
24. FUNERAL DIRECTOR Robert A. DeSol	ADDRESS Washington D.C.	25a. REC'D. BY REGISTRAR DATE OCT 21 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14704

CERTIFICATE OF DEATH

14712

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. In any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY MONTGOMERY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) d. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 15 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 11021 MADISON ST KENSINGTON		d. STREET ADDRESS 11021 MADISON ST	
3. NAME OF DECEASED (Type or print) JAMES EDWARD MEDLAR		First JAMES	Middle EDWARD
3. NAME OF DECEASED (Type or print) JAMES EDWARD MEDLAR		Last MEDLAR	4 DATE OF DEATH OCTOBER 1 1968
S SEX MALE	6 COLOR OR RACE CAUC	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH SEPT 16, 1908		9 AGE (in years lost birthday) 60 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLANT PLANNING		10b. KIND OF BUSINESS OR INDUSTRY Govt Printing Office	
11 BIRTHPLACE (County & State, or foreign country) BURLINGTON, VT		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN MEDLAR		14. MOTHER'S MAIDEN NAME MASEL BROWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO 515-43-711845	
16. SOCIAL SECURITY NO 008-03-3817		17. INFORMANT WIFE YVETTE MEDLAR	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. HYPERTENSION AND DIABETES		Address KENSINGTON 11021 MADISON ST	
		INTERVAL BETWEEN ONSET AND DEATH 5 MINS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201		19. WAS AUTOPSY PERFORMED? NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) NO		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) None	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) —
20f. (City or town) —		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1964 to 1 OCTOBER 1968 , that (I) (we) last saw the deceased alive on 25 JULY 1968 , and that death occurred at 1001 M , from causes and on the date stated above		22b. DATE SIGNED 1 Oct 1968	
22a. SIGNATURE FREDERICK S CALDWELL		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) FREDERICK S CALDWELL		22d. ADDRESS TENNEY BLDG ROCKVILLE MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/68	23c. NAME OF CEMETERY OR CREMATORIALy Gate of Heaven Cemetery, Silver Spgs. Montg. Md.
23d. LOCATION (City or Town) Montgomery, Maryland		(County) (State)	
24. FUNERAL DIRECTOR ROBERT A. PLUMPHREY, Bethesda, Maryland		25a. ADDRESS 7557 Wisconsin Ave	25b. REC'D BY REGISTRAR DATE OCT 2 1968
		25c. REGISTRAR'S SIGNATURE Charles Judge	



CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Postage and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Postage and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>Anna</i>	Middle <i>Mehler</i>	Last <i></i>	2a DATE OF DEATH Month <i>10</i>	Day <i>9</i>	Year <i>68</i>	2b HOUR <i>2 p.m.</i>
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>12-6-1876</i>		6 AGE (in years (as of today) YRS. <i>91</i>	IF UNDER 1 YEAR MONTHS <i></i>		
7a BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>		
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13c CITY OR TOWN <i>Mont. Chevy Chase</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>3 Fairfax Court</i>	
14 FATHER'S NAME <i>William H. Lipscomb</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Anna Raleigh</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO <i>219-54-7466</i>		17 INFORMANT <i>Mrs. Dorothy Riviere-Dauphin</i>		Address <i></i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ADENOCARCINOMA, COLON, WITH METASTASES</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ARTERIOSCLEROTIC HEART DISEASE WITH CONGEST. FAILURE</i> 6 mo. DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>last 15 yr.</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ARTERIAL OCCLUSION, RIGHT FOOT ARTERIOSCLEROTIC</i>							
19a DATE OF OPERATION <i>9-25-68</i>	19b CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ADENOCARCINOMA OF COLON</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM STREET, FACTORY OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <i>1965</i> , to <i>OCT. 9, 1968</i> , that (I) (we) last saw the deceased alive on <i>OCT. 9, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Leo M. Curtis M.D.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c DATE SIGNED <i>10-9-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>LEO M. CURTIS, M.D.</i>		22e. ADDRESS <i>8218 WISCONSIN AVE., BETHESDA, MONT., MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10/12/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) <i>Suitland</i>	(County) <i>Pr. Geo. Md.</i>		(State)
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	25a. ADDRESS <i>7557 Wisconsin Ave.</i>		25a. RECD BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)			First Mary	Middle Frances	Last MELENDEZ	2a. DATE OF DEATH Month 4 October 1968	Year	2b. HOUR 3:08 PM			
3. SEX Female		4 RACE Cauc		5. DATE OF BIRTH 4 October 1968		6. AGE (In years last birthday) YRS. 2		IF UNDER 1 YEAR MONTHS 2	IF UNDER 24 HRS HOURS 14714	MIN 47	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) N/A		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 112 S. Court House Rd.			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Virginia		13c. CITY OR TOWN Arlington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 112 S. Court House Rd.					
14. FATHER'S NAME George C. MELENDEZ		15. MOTHER'S MAIDEN NAME Margaret PRADO									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO N/A		17. INFORMANT George C. MELENDEZ Arlington, Virginia							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity, 2500 Grams, Female 1167 (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause) (b) Atelectasis, Bilateral DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No.		City or Town		County		State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4 October, 1968, to 4 October, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4 October 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>J. G. Flemming</i>		22c. DEGREE PHYS.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22d. DATE SIGNED 6 October 1968	
22d. PHYSICIAN'S NAME (Type) J. G. FLEMMING		22e. ADDRESS Naval Hospital, Bethesda, Maryland									
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 10/8/68		23c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery		23d. LOCATION (City or Town) Arlington, Va.		(County)		(State)	
24. FUNERAL DIRECTOR Taltavull Funeral Home		ADDRESS 4748 Wisconsin Ave. N.W. Washington, D.C.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	20. DATE OF DEATH Oct. Month 15 Doy	2b. HOUR 1008 Year 105 PM	
1. DECEASED NAME (Type or print)		L.A. Rue	W.	Melendy	S. DATE OF BIRTH 1985-07-05	6. AGE (In years last birthday) 82 yrs.	
3. SEX		4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS M.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED NEVER MARRIED DIVORCED	9. COUNTY OF DEATH	Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	Address		
		460-44-6574		Jeanine Melendy	Rd. 15450 Thompson Rd.		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Acute Pulmonary Edema							
4129 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) After 100 days of Heart Disease							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Cerebral Thromboses							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from May 1965 to Oct. 1968, that (I) (we) last saw the deceased alive on Oct. 15 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph E. Smith Jr. M.D.		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		Burtonsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) Rockville, Md.		(County) (State)
24. FUNERAL DIRECTOR Arthur Walters		Oct. 21-1968	ADDRESS 254 Carroll St. N.W. Washington, D.C. 20012		25a. REC'D. BY REGISTRAR DATE OCT 21 1968	25b. REGISTRAR'S SIGNATURE George J. ...	



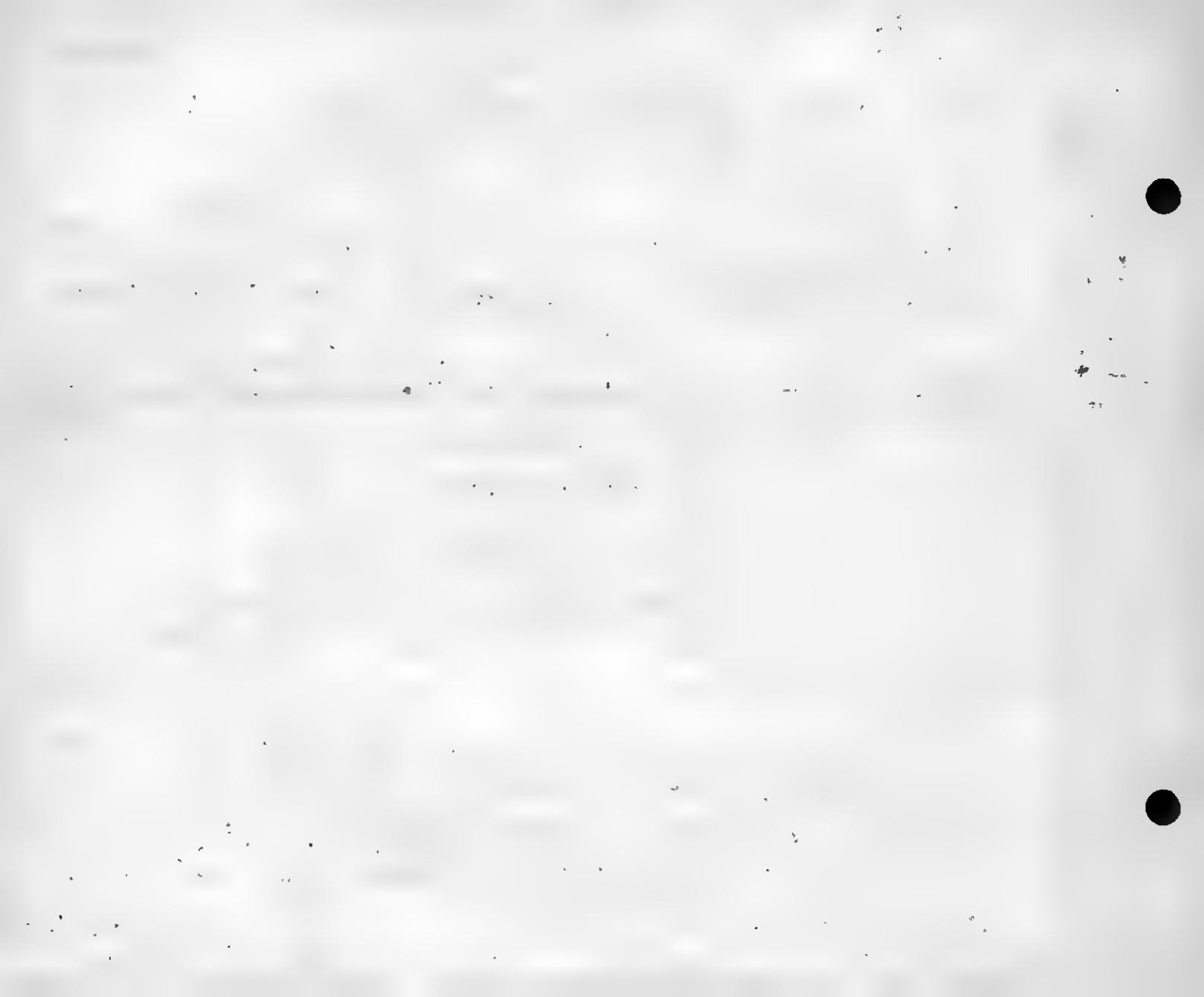
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14708

14716

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)				First Charles	Middle Joseph	Lost Merrill	2a DATE OF DEATH Month October	2b HOUR A.M. Day 7 Year 1968					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 28 September 1943		6. AGE (in years last birthday) 25		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0			
7a BIRTHPLACE (State or foreign country) New York		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery							
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk			12b KIND OF BUSINESS IND. STRY Rental Agency				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New York			13c CITY OR TOWN Zone Park			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 9459 Plattwood Avenue					
14. FATHER'S NAME Arthur				15. MOTHER'S MAIDEN NAME Merrill		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (or unknown) No				17. INFORMANT Bethesda, Maryland Address Not Available The Medical Records, The Clinical Center,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Right lower lobe pneumonia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				DUE TO, OR AS A CONSEQUENCE OF (b) Acute lymphocytic leukemia				5 years					
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
MEDICAL CERTIFICATE ON		19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3 Sept., 1968, to 7 October, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7 October 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.													
22b. SIGNATURE <i>Edward S. Henderson</i>		40 DEGREE		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 7 October 1968			
22d. PHYSICIAN'S NAME (Type)		Edward S. Henderson, M. D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-10-68		23c. NAME OF CEMETERY OR CREMATORIAL —		23d. LOCATION (City or Town) New York City, NY		(County) —		(State) —			
24. FUNERAL DIRECTOR <i>W.W. Chambers Co 1405 Clifton St New</i>		ADDRESS <i>Washington, D.C.</i>		25a. REC'D BY REGISTRAR OCT 10 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



~~FOR STATE
HEALTH DEPT.~~

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14717

1. DECEASED-NAME (Type or Print)			First Clara	Middle Marie	Last Metes	2a DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/>	Month Oct.	Day 11	Year 1968	2b HOUR 8:55 AM	
3. SEX Fe	4 RACE W	5 DATE OF BIRTH 6-29-24	6 AGE (In years at birthday) 44	7 IF UNDER 1 YEAR MONTHS YRS	8 IF UNDER 24 HRS DAYS	9. COUNTY OF DEATH Montgomery	2c. DATE PRONOUNCED DEAD Month Day Year Oct. 11 1968				
7a BIRTHPLACE (State or foreign country) Hungary		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	W-DOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	2d HOUR 9:00 AM	
10. CITY OR TOWN OF DEATH Takoma Park			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hospital			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b KIND OF BUSINESS OR INDUSTRY own home		
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Md.			13c CITY OR TOWN Mont.			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 402 Lexington Dr.		
14 FATHER'S NAME Stephen Nicholas Modly			15 MOTHER'S MAIDEN NAME Gizella			16 SOCIAL SECURITY NO. 579-42-3852			17 INFORMANT Mr. Mircea U. Metes 402 Lexington Dr.		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b ADDRESS Sil. Spr. Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture. Cerv. col spine with Transsection. DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden.		
						(b) of Spinal Cord.					
						(c) Trauma Auto. Accident					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year 8:45 AM 10/11 1968			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Car out of control struck utility pole.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway.			21f LOCATION Street or R.R.D. No. University Blvd. - S. New Spring Mont. Md.			City or Town	County	State
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John G. Ball			EXAMINER'S NAME (Type) John G. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (street, city, town, or county) Sil. Spr. Mont. Md.			22b DATE SIGNED Oct. 11, 1968.		
23a BURIAL, CREMAT. ON, REMOVAL (Specify) Burial at Glen Carter			23b DATE 10-15-1968			23c NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery			23d LOCATION (City or Town) Sil. Spr. Mont. Md.		
									25a REC'D BY REGISTRAR Warren E. Humphrey, Inc. 8434 Ga. Ave. S.S., Md.		
									25b REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First <i>DONALD</i>	Middle <i>Cawsey</i>	Last <i>MICHELL</i>	20 DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI DEATH MATED <input type="checkbox"/> Oct 29 1968	2b HOUR 7:22 P.M.
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday) - YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year 10 29 1968	2d HOUR 7:55 P.M.
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>		
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Md	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Maryland</i>	13b COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Bethesda</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>4808 WELLINGTON Dr</i>	13f ADDRESS <i>148-24 Chevy Chase Dr.</i>	
14. FATHER'S NAME	First <i>Joseph J. Mitchell</i>	Middle	Last	15 MOTHER'S MAIDEN NAME	First <i>Louise Cawsey</i>	Middle
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO <i>W.W. II 111-22-4775</i>	17. INFORMANT <i>Laboros Mitchell</i>	ADDRESS <i>148-24 Chevy Chase Dr.</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive gastrointestinal hemorrhage</u>						
DUE TO, OR AS A CONSEQUENCE OF <u>Ruptured esophageal varices</u>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Advanced liver cirrhosis, Laennec's type</u>						
DUE TO, OR AS A CONSEQUENCE OF <u>Years</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>John G. Ball</i>		22b. DATE SIGNED <i>Oct 30, 1968</i>		
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>Nov. 1, 68</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National</i>	23d LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>		
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>		25a ADDRESS <i>2557 Wisconsin Ave.</i>	25b REC'D BY REGISTRAR <i>NOV 4 1968</i>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14711 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14719

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOUR	
ESTHER			BELL	MONTGOMERY		OCT	6	1968	2 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	F. UNDER 1 YEAR MONTHS	I. F. UNDER 24 HRS DAYS	HOURS	M.N.				
FEMALE	WHITE	3/26/04	64 YRS								
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U. S. A.		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>		MONTGOMERY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA			SUBURBAN			School TEACHER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN		13d. INSIDE CITY, MTS?		13e. STREET AND NUMBER				
MARYLAND			CARROLL		WESTMINSTER		YES <input type="checkbox"/>	NO <input type="checkbox"/>	128 E. MAIN ST.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
BRADFORD			BLIZZARD			NANCY			SYPE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT			ADDRESS SAME ADDRESS		
No			220-36-8580			WILLIAM MONTGOMERY - HUSBAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											
PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>Massive hemorrhage, intra-thorax, left</u>											
DUE TO, OR AS A CONSEQUENCE OF											
4411 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured saccular aneurysm, thoracic aorta</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Arteriosclerosis, marked.</u>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Sudden											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
441X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?					
									YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			John E. Bell			CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town) (County) (State)		
BURIAL			10/10/68			TRINITY LUTHERAN CEMETERY SMALLWOOD, CARROLL, MD					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REG STRAR			25b. REGISTRAR'S SIGNATURE		
J. E. Myers Jr., Funeral Director, Inc.			Westminster						Oct 10 1968 J. Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14712

14720

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First JAMES	Middle E.	Last MOONEY	2d. DATE OF DEATH Month 10	Day 27	Year 68	2b. HOUR 11:30 A.M.
3. SEX M		4. RACE W		S. DATE OF BIRTH 7/30/01	6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery		12b. IND OF BUSINESS OR INDSTRY Montgomery	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Montgomery Hospital		12b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hours		
13a. US. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Montgomery		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 11707 Tudor Place		
14. FATHER'S NAME First Edward		Middle Mooney	Last Massey	15. MOTHER'S MAIDEN NAME First Mildred		Middle E.	Address Mildred M. Mooney wife - 5200	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. -		17. INFORMANT Vivian Lee Faber				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4127 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Arteriosclerotic heart disease		DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease		DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) +100								
19a. MEDICAL CERTIFICATION DATE OF OPERATION 7/28/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) Not applicable		21b. TIME OF INJURY HOUR A.M. Month Day Year 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.) Office Building		21f. LOCATION Street or R.F.D. No 5323 Conn. Ave. N.W.		City or Town Washington, D.C.	County D.C.	State D.C.
22a. I certify that (I) (this hospital) attended the deceased from 9/28 , 19 64 , to 10/27 , 19 68 , that (I) (we) last saw the deceased alive on 10/27 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Jack P. Segal		DEGREE MD	ATTENDING PHYS.	AT	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) Jack P. Segal, MD		22e. ADDRESS 5323 Conn. Ave. N.W.		22f. DATE SIGNED 10/28/68				
23a. BURIAL/CREMATION BURIAL		23b. DATE 10-30-1968		23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery		23d. LOCATION (City or Town) Washington, D.C.		(County) D.C.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS 5130 Wisc. Ave.		25a. REC'D BY REGISTRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



H
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14721

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon borders (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>John</i>	Middle <i>J.</i>	Last <i>Moorhead</i>	2a. DATE OF DEATH <i>October 1 Day 1968</i>	2b. HOUR <i>1:00 PM</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>May 24, 1895</i>		6. AGE (in years last birthday) <i>73</i>	IF UNDERR 1 YEAR MONTHS <i>YRS.</i>	IF UNDERR 24 HRS. HOURS <i>MIN.</i>
7a. BIRTHPLACE (State or foreign country) <i>Indiana</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Montgomery</i>	Md.		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>805 New York Avenue</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Physicist</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Chemical</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Sil. Spr.</i>	13d. INSIDE CITY LIMITS? <i>YES</i>	13e. STREET AND NUMBER <i>805 New York Avenue</i>		
14. FATHER'S NAME First <i>George</i>	Middle <i>Moorhead</i>	15. MOTHER'S MAIDEN NAME First <i>Alice</i>	Middle <i>Vincent</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16b. SOCIAL SECURITY NO. <i>400 7</i>	17. INFORMANT <i>Mrs. Phila E. Dawson</i>	Address <i>Ind., Indiana 3229 S. Keystone Ave.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HYPERTENSION</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 HRS.</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>f 3 3 4</i>						
(b) DUE TO, OR AS A CONSEQUENCE OF <i>ARTERIOSCLEROSIS, GEN.</i>				15 yrs.		
(c) DUE TO, OR AS A CONSEQUENCE OF						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION <i>10-2-1 X</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>at work</i>	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>While Not while at work</i>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <i>7950 New Hampshire Ave. Sil. Spr. Md.</i>	City or Town <i>Georgetown</i>	County <i>Maryland</i>	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>9/24 1968</i> , to <i>10/1 1968</i> , that (I) (did) lost saw the deceased alive on <i>9/24 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did) view the body after death.						
22b. SIGNATURE <i>L.B. Snow M.D.</i>	DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10 Oct. 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>L.B. Snow M.D.</i>	22e. ADDRESS <i>7950 New Hampshire Ave. Sil. Spr. Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>	23b. DATE <i>10-2-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Lincoln Crematory</i>	23d. LOCATION (City or Town) <i>Pr. Georges</i>	(County) <i>Maryland</i>	(State)	
24. FUNERAL DIRECTOR <i>Warren E. Pumphrey, Inc.</i>	ADDRESS <i>8434 Georgia Ave.</i>	25a. REC'D. BY REGISTRAR <i>Sil. Spr. Md.</i>	25b. REGISTRAR'S SIGNATURE <i>OCT 4 1968 Charles Judge</i>	DATE		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in part 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Dept. prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14722

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First KENNETH	Middle WILLIAM	Last MORONEY	2a DATE KNOWN OF ESTI- DEATH MATED	Month Oct	Day 24	Year 1968	2b HOUR 10PM		
2 SEX M.		4 RACE W.	5 DATE OF BIRTH 1/19/1898	6 AGE (in years at birthday) 70 yrs	7 UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9 COUNTY OF DEATH Montgomery	2c DATE PRONOUNCED DEAD Month Oct	Day 24	Year 1968	2d HOUR 10PM	
7a BIRTHPLACE (State or foreign country) Person A.		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery						
10 CITY OR TOWN OF DEATH Chevy Chase.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) 5410 Grove Street		12a. USJAL OCCUPATION (Kind of work done during most of working life, even if retired) Lawyer Retired -		12b KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5410 Grove Street					
14. FATHER'S NAME William.		15. MOTHER'S MAIDEN NAME Moroney.		16. MOTHER'S MAIDEN NAME Elle Margaret		17. ADDRESS Mrs. Rita Lloyd Moroney, wife, same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Coronary Insufficiency Acute- Sudden				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
(b) Hyperensive Cardiovascular Disease Years.		DUE TO, OR AS A CONSEQUENCE OF										
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201												
19a. DATE OF OPERATION MEDICAL CERTIFICATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Oct 24, 1968				
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 10-28-1968		23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN CEMETERY		23d. LOCATION (City or Town) Silver Spring, Montgomery Co.		(County)		(State) Md.		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C. 20016		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 30 1968		25b. REC'D STAR'S SIGNATURE Charles Judge						
VR 15ME (5) TOM REV 1/68												



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

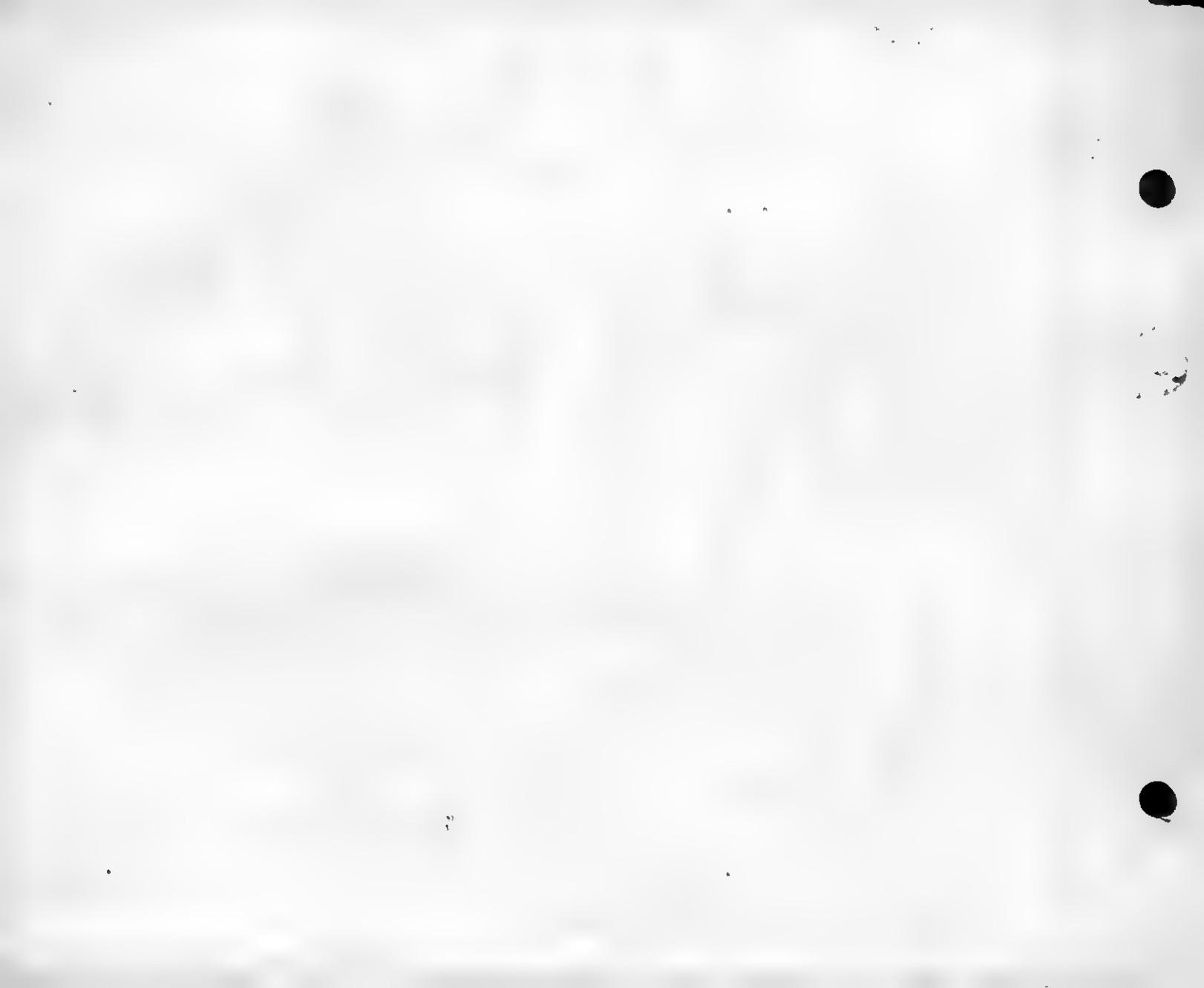
CERTIFICATE OF DEATH

14723

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Boxes 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Clara	Middle Martha	Last Morrison	2a. DATE OF DEATH October Month 14 Day 1968	2b. HOUR P 10:45 M	
3. SEX Female	4 RACE Negro	5. DATE OF BIRTH 11/28/95		6. AGE (In years last birthday) 72 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Olney	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 15528 Bailey's Lane		
14. FATHER'S NAME Arthur	First Middle Lockman	Last Martha	15. MOTHER'S MAIDEN NAME Toogood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOC. SECUR. NO.	17. INFORMANT Records	Address Montgomery General Hospital, Olney, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 410.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis - Coronary and General				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 420.1 Broncho pneumonia				years		years.
19a. DATE OF OPERATION 420.1	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Oct 14 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						1956, 19, to Oct 15, 1968
22b. SIGNATURE Richard A. Yates	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/15/68.		
22d. PHYSICIAN'S NAME (Type) Richard A. Yates, M. D.	22e. ADDRESS Old Baltimore Road, Olney, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-18-68	23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial	23d. LOCATION (City or Town) Silver Spring, Md.	(County)	(State)	
24. FUNERAL DIRECTOR Robert L. Snowden - Rockville, MD	ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 30M REV						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14716

CERTIFICATE OF DEATH

14724

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

KENSINGTON

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

KENSINGTON GARDENS NURSING HOME

3. NAME OF
DECEASED
(Type or print)

First

Middle

NELLIE B

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Dec 27 1889

78 yrs.

9. AGE (In years
(last birthday))10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James McGuire

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

N.A.

17. INFORMANT

JOHN J. MORSE JR

Address

14. MOTHER'S MAIDEN NAME

ANNIE GORVIN

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ARTERIOSCLEROSIS - SEVERE

440.9

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

10 YRS

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

20d. INJURY OCCURRED

White Not White at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1957 to 1968, that (I) (we) last
saw the deceased alive on 10/17 1968, and that death occurred at 2 A.M., from the causes and on the date stated above.

22e. SIGNATURE

Henry W. Stout

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
10/8/6822c. PHYSICIAN'S
NAME (Type)

Henry W. STOUT.

22d. ADDRESS

10011 GEORGIA AVE SILVER SPRING MD

(State)

23a. BURIAL
REMOVAL
(Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

Burial Oct 11, 1968

Date of Death

Silver Spring MD

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

DATE OCT 10 1968

25b. REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then leave remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7, 61



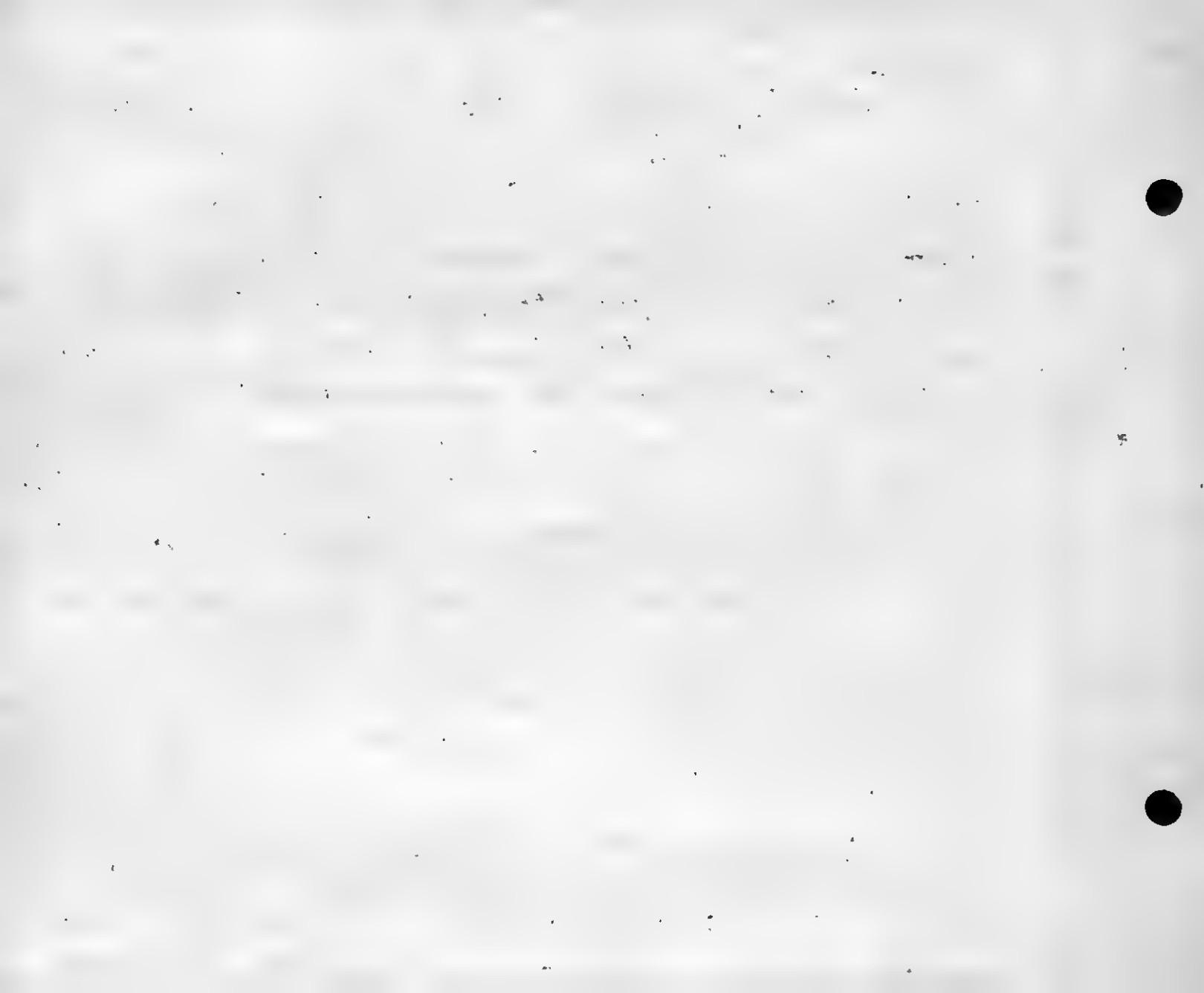
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

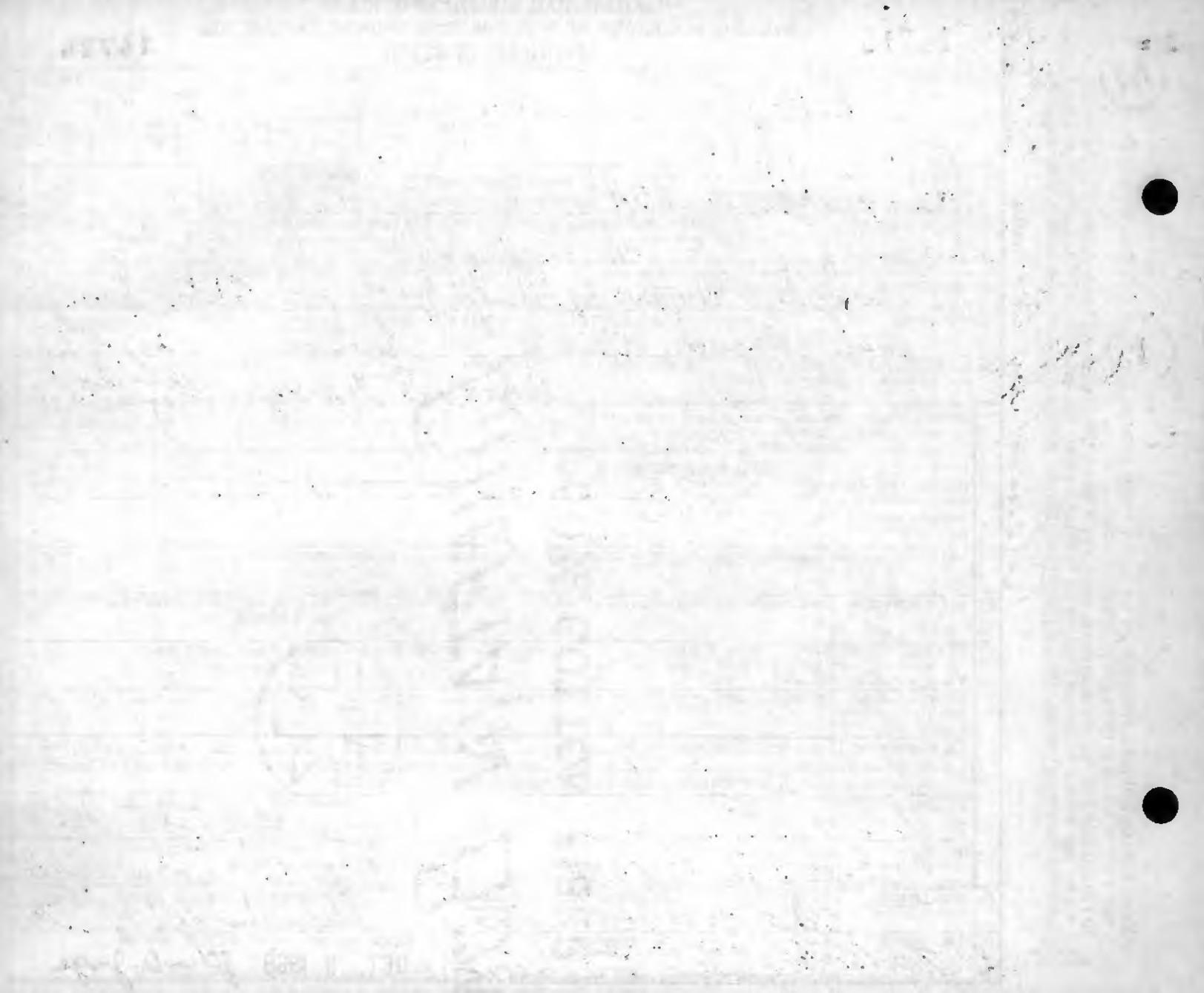
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1 DECEASED-NAME (Type or print)		First <i>Roger</i>	Middle <i>Sylvester</i>	Last <i>Moss</i>	2a. DATE OF DEATH Month <i>10</i>	Doy <i>8</i>	Year <i>1968</i>	2b. HOUR <i>7 A.M.</i>
3 SEX <i>Male</i>	4 RACE <i>white</i>	5. DATE OF BIRTH <i>1-4-00</i>		6. AGE (In years last birthday) <i>68 yrs.</i>	IF UNDER 1 YEAR MONTHS <i>6</i>	IF UNDER 24 HRS DAYS <i>8</i>	HOURLY MIN <i>7 A.M.</i>	
7a. BIRTHPLACE (State or foreign country) <i>West Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>America</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Montgomery</i>					
10 CITY OR TOWN OF DEATH <i>Takoma Park</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Sanitarium Hosp</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Self-employed</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate Broker</i>				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? <i>YES</i>	13e. STREET AND NUMBER <i>756 Brantford</i>				
14. FATHER'S NAME First <i>Joseph</i>	Middle <i>T</i>	Last <i>Moss</i>	15. MOTHER'S MARRIED NAME First <i>Mary</i>	Middle <i>C</i>	Last <i>Young</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>578 46 8225</i>	17. INFORMANT <i>Hospital Records</i>	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Normal by posthe pneumonia</i> 48 hours								
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) <i>congestive heart failure</i> 72 hours								
DUE TO, OR AS A CONSEQUENCE OF <i>acute Pulmonary edema</i> 15 months								
DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic heart disease c coronary insuff 2 years</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>420i</i>								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>10/3/68</i> , to <i>10/8/68</i> , 1968, that (I) (we) last saw the deceased alive on <i>10/2/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did-not) view the body after death.								
22b. SIGNATURE <i>N.J. M.D.</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/8/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>J.W. Trey O.D.</i>		22e. ADDRESS <i>7105 Kicks Road, Lewisdale, Md.</i>						
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Urinal</i>	23b. DATE <i>10/10/1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Rosedale Cemetery</i>	23d. LOCATION (City or Town) <i>Martinsburg</i>	(County) <i>W.Va.</i>	(State)			
24. FUNERAL DIRECTOR <i>alley's Funeral Home Mt. Rainier, Md.</i>	ADDRESS <i>1111</i>	25a. REC'D BY REGISTRAR <i>OCT 14 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Gordan</i>					





FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File papers with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- MATED	Month	Day	Year	2b. HOUR 6 PM
<i>Theresa Margaret Musgrove</i>						<input checked="" type="checkbox"/>	Oct 6	1968	6 20 PM	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR 6 PM	
Fe.	W.	Oct 4, 1880	88 yrs			Oct	6	1968	6 20 PM	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH						
Maryland	U.S.A.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Montgomery						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY					
Wheaton	Wheaton Nursing Home.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
Md.	Montgomery	Wheaton	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	1701 Arcola Ave.						
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
R. Thomas Sullivan				Agnes F. O'Donahue			Sullivan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	ADDRESS							
No	213-50-9191	J1 Edna Forsyth	same item + 13 - daughter							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema Acute</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
887X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerotic Heart Disease</i> (c) <i>Generalized Arterio Sclerosis</i>								10 Days - Years. Years.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>9040 Compression Fracture of 12th Dorsal Vertebra</i>										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?						
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR AM P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <i>Fell at home, injuring back.</i>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State						
	Home	1701 Arcola St.	Wheaton	Montgomery, Md.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE	<i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)	John G. Ball 7936 Old Georgetown Road, Bethesda, Md.			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City or Town)	(County)	(State)					
Burial	10/9/68	St. Johns Cemetery	Forest Glen	Montg.	Md.					
24. FUNERAL DIRECTOR	13 ADDRESS	Pike Rock.	25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE						
Tyson Wheeler Funeral Home	Rockville, Md.		OCT 8 1968	<i>Charles Judge</i>						

TEST